Exhibit X

DEPARTMENT OF POLICE ACCOUNTABILITY

DPA CASE NO.: 0164-16

INTERVIEW OF: LIEUTENANT MARIO MOLINA, #1586, PART TWO

DATE OF INTERVIEW: 05/16/2018

INV. STONECIPHER: This interview is regarding DPA Case number 0164-16, and it's taking place at the Department of Police Accountability on May 16th, 2018, at 20:01 a.m. It's a continuation of a member interview with Lieutenant Mario Molina, Star number 1586, who had been brought in as a subject matter expert speaking on CIT. Conducting this interview is Investigator Matt Stonecipher with the Department of Police Accountability. Also present is…

SR. INV. VILLARREAL: Carlo Villarreal, Senior Investigator.

INV. STONECIPHER: Okay. So, where we left off last time you came in, I think we were talking about the topic of verbal de-escalation scenarios, and where that kind of plays in the CIT program. So, I know one of the concepts is developing a rapport with an individual in the scenario, where someone who isn't crisis responding to a person who is in crisis. Like what is the goal of developing a rapport with an individual in a scenario like that?

LT. MOLINA: Well, every case is different. It depends on what you go into. If you're dealing with a person that just has a mental health issue, nothing else, there's no weapon

involved, just for instance, a suicidal person that just wants to end it all, and you're responding to this call. The person has not committed a crime, is not in possession of any weapon, and basically, just [stuck] to himself or herself. So, you want to get there, create time and distance. Right?

INV. STONECIPHER: Uh-huh.

LT. MOLINA: Build a rapport, get to know the person. Obviously, he or she might be agitated. He or she might be doing some type of behavior that caught the attention of...he might have called 911. Usually, we'll get that, like I'm feeling suicidal, I'm going to kill myself. So, you want to get there. You want to establish communication to begin with. Make sure that he and you are safe, depending on what the location is and what the situation is at the time.

INV. STONECIPHER: Yeah.

LT. MOLINA: So, you want to communicate. You want to, "Hey, what's going on today?" Open [unintelligible] questions. Right? You don't want to judge, you [want to know] what's going on, and depending on what the answer is, then you continue on. So, basically, it's just assure the person that you're there to help them. You know, "I'm here to help you out. I heard that you're going through a rough patch," or whatever it is that you're doing. So, get them to talk to you. You don't want to lie to them, like you know, this is going to happen; "If you decide, it seems like you need help, you want to talk to me." Sometimes people don't want to talk to the first officer, they might want to talk to the second officer.

Whatever the situation is, you've got to build that rapport

and use a lot of empathy and active listening. I think that's the best way because you don't judge. You have to reflect the emotions. Like, "Fuck you, I didn't call you." "Well, it just seems like you're very angry right now."

INV. STONECIPHER: Yeah.

LT. MOLINA: Instead of, "Uh, fuck me? No, fuck you." Right? No, it's like, "Hey, it seems like you're going through a lot of rough time right now," and put it back to them. Sometimes you get, "Yeah, yeah." "Well, do you want to talk about it?" So, that's the type of [establishment] at the beginning. You want to establish the rapport, if it's feasible. It all depends on what the situation is, because as you know, police work is not black and white.

INV. STONECIPHER: Yeah.

LT. MOLINA: So, it depends on what you have, but that's the first line of communication. Establish rapport, active listening, and empathetic responses.

INV. STONECIPHER: Okay. Now, are officers taught what to do when they respond to a scene with someone in crisis, and other officers are already implementing de-escalation tactics?

LT. MOLINA: So, we do talk about it, and that started in 2016, 2017, when we started talking about tactical response. We did talk about it in the past, prior to 2015, but it wasn't as much as it is now. You respond to a scene and there's an officer already talking to somebody, and that he or she is doing great, and he or she might not be CIT trained and you are.

INV. STONECIPHER: Uh-huh?

LT. MOLINA: We don't want officers to, "Step aside, I'm

CIT trained. Let me talk to this person." No, we want them to respond to the scene, learn what's going on. If the officer has already established communication with that person, is doing great, you would be the secondary person...eyes and ears for that officer. You see reactions like, "When you say this, he's reacting like that. Don't say it again, because that gets him mad." So, you continue feeding information to that person, so you don't go cut him off, but if the officer is struggling and not getting anywhere with that person, then yeah, you intercede.

And the rest of the officers that are arriving on the scene, we're assigning roles now. In the policy now, we have a team response as of 2016, the policy passed in 2016, December 21st, 2016. So, now, officers who respond to a call and we ask them to identify themselves, whether they are CIT trained, tell him it depends if there's a weapon involved, no weapon involved. If there's an edged weapon, a blunt weapon, they have to say that they have the ERIW with them; supervisor has to respond. If there is no urgency, then they stop [unintelligible], and they proceed as a team.

INV. STONECIPHER: Now, would the primary officer who developed the rapport, also be the contact officer if force needs to be used?

LT. MOLINA: It depends, it all depends. It's just if you said de-escalation, CIT, it's not set, it's just tools. Okay? It depends on what you're dealing with, like any police matter. We would like the communicating officer to actually establish the rapport, to build the trust, so the person complies without force. But at the same time, you have to be

ready for anything. Obviously, you might be the focus of the anger, because you're the one talking to him; all the communication goes back and forth between you and him. So, it depends what's feasible at the time, it's not like, "Okay. You've got to do this. You got to do that." No, it's flexible.

INV. STONECIPHER: And how are officers trained to identify when the verbal de-escalation techniques are not working and force needs to be used?

LT. MOLINA: Well, we talked about it. It's just like I said, it's not written in stone that you've got to do A, B, C. It's just, it's guidelines, this is what happens. What we tell our officers, if you're responding to a situation when you are arriving, and you're dodging bullets, or you're dodging because somebody is throwing things at you, or somebody's getting hurt, there is no time to de-escalation, it's time to act. You have to act to protect life, either the person who's being attacked, your own life, because you're being shot at or you're being attacked, or somebody else is being attacked, then you have to do something. There's no, "Excuse me, sir. Can you please stop stabbing that person?" No, you don't do that, you have to react to what's going on.

Now, if you're responding to a situation where a person is armed with a weapon and he's lashing, or he's doing...but he's not hurting anybody, and then you start calling resources. The primary role is to make sure that you're safe, to begin with, so you can help other people, that the person in crisis is safe, the public is safe. You start getting your resources, start communicating on the radio, asking for resources, asking for a

supervisor, and so forth. You might be the one grabbing the person, there might be a plan. When everything is established and the person is still acting erratically, you, "Okay. I'm going to get him to talk to me. I'm going to tell him to come towards me, and then I'm going to have to use force to contain him obviously." You spent 20, 30 minutes, sometimes we spend hours, sometimes days, talking to people. So, there's not a designed time that we say, "Okay. We're going to [go force] on somebody," so it depends.

INV. STONECIPHER: Yeah. Now, on the topic of mental health disorders now that's taught in the CIT program, how is this topic taught? Is it lecture, reading, videos? How do you [inaudible] the program?

LT. MOLINA: No, it's lectures, it's videos, it's a little bit of everything. So, we have instructors, most of them are civilians, and mental health…if you go by blocks. Right? So, we have trauma, we have PTSD, and then [confinement] to help signs and symptoms. That was just yesterday, and that's a two-hour block with [redacted], she is a psych nurse that works at PES, and this is now. This is now. [redacted], near Daly City, and they both talk about it. One talks about the mental health side of it, and the other one as the experiences of working as a police officer working with [BETS] and stuff. And they talk about symptoms, they have videos of people going through a crisis, schizophrenics; people diagnosed with schizophrenia. They talk about bi-polar disorder, schizophrenia

spectrum analysis spectrum. It used to be just schizophrenia, now it's like autism, they say that you're both in the spectrum. They talk about medications, they recommend apps. Like side drugs that come, is an app, that an officer, or anybody, can download that, look at that, and you want to identify medications like the person might have on them, and you can see what the medication is for. They talk about exciting delirium, which is very important. In San Francisco especially, with people using narcotics and bath salts, so that's part of mental health signs and symptoms.

We also have people from SOLVE, S-O-L-V-E, Sharing Our Lives and Experiences, and that's put on by the Mental Health Association in San Francisco at 870 Market. So, we have a panel of consumers that come in, and they talk about their own experiences with mental health, how they got affected by their illness, how they bounced back. We have a professor from USF that comes and talks about it, and he will tell you he's diagnosed with bi-polar and how he has dealt with that illness through his entire life. We have another consumer who's part of the CIT work group, [redacted], a psychologist, and he comes and talks about how mental health affected him, and how he bounced back, and his experience with the police in the Tenderloin.

So, not only do we do lectures, we show videos, we do scenarios, but also, we talk about our own experiences. We also have a NAMI parent that comes in. He has a son who's a police officer, and a son who's diagnosed with schizophrenia, and he talks about the balance between the two. He's worried about both

of them, the older boy who's diagnosed with schizophrenia, and the police officer. So, we talk about his own experiences. He talks about approaches, how he dealt with his kid's illness throughout his entire life, since he was 15. And how hard it was also, for him to watch the news and see police officers involved in shooting people with mental health issues, like across the nation and stuff. So, he talks about that.

We also have SOLVE, mental health, NAMI, suicide prevention. They talk about mental health stuff that they deal with. So, it's an array of different topics.

INV. STONECIPHER: Now, was this taught differently, prior to December of 2016, this topic?

LT. MOLINA: The panels were the same. Obviously, different parents, different presenters. The dad wasn't there from NAMI. It was family members that NAMI will have as volunteers, come and talk to us, prior to 2016. [redacted], she was teaching back in 2015, but she was being guided by Doctor [redacted], who is the head psychiatrist at the hospital down in the peninsula. It was basically more like lectures, videos…similar, but different instructors. What else? We had the role plays that talked about mental health, like officers get dispatched to a call of a person who might be suicidal, the person might be acting erratically, and then they have to kind of walk through it, develop a rapport, and again, they help [unintelligible].

INV. STONECIPHER: Now, you mentioned it kind of briefly, a little bit ago, but I just want to clarify. Like there's a wide gamut of mental health disorders that exist.

LT. MOLINA: Right. Right.

INV. STONECIPHER: So, do you focus on just a few in the training, or is it like more get certain time than others, or how do you [inaudible]?

LT. MOLINA: We try to balance, it's pretty much the instructor's job, it's not mine. It's the instructor, and they balance what they see, which is mainly bi-polar disorders, schizophrenia, those are the two main ones. Especially schizophrenia spectrum, because they're the ones that usually will create the delusions, it will create the grandiose, it will create the episodes. But there's an array of them, but they have a format that they follow.

INV. STONECIPHER: Now, what are the signs and clues that officers are taught to look for to identify that this is a mental health issue that they're walking into?

LT. MOLINA: Well, like I said, it's not black and white like that. I wish it was. I wish it… "Johnny, this is what he did it with today." No, it doesn't work like that. It doesn't, because a lot of the mental health issues are also masked by drug use. So, you might have the same situation, and you think, "Okay. What do I have here? Is it a psychosis? Is it an organic issue or is a chemical issue?" This person just smoked some meth and is seeing the demon in the corner, or is it, okay, he's schizophrenic, and then he's seeing delusions. Right? So, what we do is we tell the officers, "You're not a doctor. You can't diagnose in ten seconds when you get there and you assess what's going on. Okay? So, you concentrate on the behavior, concentrate on the behavior. Create time and distance, use active listening,

listen to what's going on. Talk to the people around you, because they probably know more than you'd know when you get there. Try to get information, as much as you can; family members, pedestrians, whoever called the police. Ask for the person and keep that person safe and try to assess what's going on."

We talk to them about delusion; don't buy into the delusion. If the person says, "Don't go there. Don't go there, it's blue demons. There's blue demons." You don't go and say, "Uh, yeah, I see it." You don't do that because obviously, you don't see them. So, we have techniques that we teach them. Like in 2016, we started taking a tactical approach. It's like, "Okay. I believe you see demons. Unfortunately, I don't see the demons, but I believe that you do, so I want to help you. Can you walk away from that corner? Let's get you away from whatever you see and let's talk about it." Or if the person is hearing voices in his head and you say, "I believe that you're hearing voices, but I cannot hear any. But can you hear my voice? Can you differentiate between my voice and the voices that you're hearing?"

So, we go through that process to see whether the person acknowledged you, to see whether they actually understand what you're saying to them. Because talking to the psychologist that teaches the class, usually, when the person is hearing voices, [unintelligible] like, "You should go kill yourself, you do this," like the internal stuff that goes in. So, we do an exercise with the officers, NAMI does it, where they come in the room and we select the officers by one, twos, and threes. The

ones stays at the table, the twos and threes go out. We instruct the twos and threes to come back to the table and just speak nonsense in their ears, say bad things about what they're wearing. "Uh, my God. You're wearing that old shirt," or whatever it is. They pick something and when they come back, they're supposed to do this to the person that is sitting down.

Now, the ones get instructed to do a drawing by the instructor. He says, "Okay. The ones, listen to me. You're going to start drawing a line about two centimeters left, three centimeters high, low," whatever the instructions are, while you're listening to all these voices, and no one gets the drawing right. So, we tried to do a practical exercise on how it is for somebody to try to concentrate on doing a task when hearing voices. So, it's a good exercise that gets you a glimpse of what it might be like to have to listen to somebody talking to you, while other people are just putting things in your head and stuff. So, that's a very effective exercise. So, stuff like that.

INV. STONECIPHER: Now, does anyone from the psychiatric liaison unit help with the training for this?

LT. MOLINA: We all do.

INV. STONECIPHER: Okay.

LT. MOLINA: So, it's my unit right now. Back then, in 2014, at the end of 2014, when I became assigned to the training, basically it was just me, I was the CIT unit, and a part-time officer that was happening. Then 2015 happened, and I was transferred to the Behavioral Science Unit, which is BSU. I don't know if you guys are familiar with BSU? It provides

services to the officers for peer support, counseling, drug abuse, and lots of stuff, so I was transferred as an OIC of that unit.

So, I got help on the collateral side, from my sergeants that are dealing with the officers. That program is an internal Department program, an employee assistance program. But CIT is not, so I had to keep it kind of isolated from what the program for the officers, the program for the community. So, as of 2015, I got more help, like December 2015, and people started asking more questions about CIT. I said, "Well, I need help," so I was given a sergeant, and I was able to grab other officers part-time.

On 2016, after revising the program, I said, you know what? The role playing was done by the officers in the class, and then we hire a company of actors that came and did the role playing. I thought it was more realistic, more in tune with what we were doing. But officers cannot touch the role players, cannot use force on the role players, so it's very sterile. It basically was just around rapport building, active listening, empathetic response, and so forth. So, we felt like this is great, but we need to do more, I think we need to do more. We need to teach our officers how to respond in a tactical situation, because there was no weapons involved in these role plays. There was no person with knives, nothing.

The Memphis Model doesn't talk about that, how to respond to that. So, we felt like we needed to change the program, and that's when I went to Seattle with Sergeant Anderson, and I had [gone through] some of the training, and we came back and

completely changed the role plays. Now, we do active response to a person in crisis with an edged weapon. Active response to a person in crisis with a bat, suicidal person with a gun, [unintelligible], because we felt like that's what the officers needed. Prior to 2016, that wasn't happening in the role playing. Very sterile role playing, basically rapport building, developing trust, following-up with the mental health providers' diversion programs that we refer people to.

INV. STONECIPHER: Now, the topic of medical issues. How is that topic taught in the CIT program?

LT. MOLINA: As far as?

INV. STONECIPHER: So, you've got mental health, which is its own thing.

LT. MOLINA: Right.

INV. STONECIPHER: So, I guess medical issues would be anything that isn't, I guess. Does that make sense?

LT. MOLINA: Yeah, but medical is, I mean we don't address medical, unless First-aid, that's something else that they get, right, and a different type of training. We do address autism. It's not a mental illness, because autism is a developmental issue. The difference is that mental health, you can sometimes improve your way of life by taking medications, by receiving therapy. Autism and developmental issues, it doesn't matter how much you take or how much you do, you're still going to have that issue, because it's there for life. It's chronic, a developmental issue, like autism. Medication might help a little bit to calm down some of the behavior, but it will never improve as much as mental health issues will.

So, we do have [redacted]. She works for the Mayor's Office, she was from Disability, and she comes and talks about autism and how to identify it. We also put a video together, the San Francisco PD. I don't know if you guys have seen the video, but how to respond to a call for any autism person. I asked for volunteers, and two officers, they have children that are autistic, volunteered, because not only they bring their own experience of dealing with their own kids, but also how they deal as an officer, and that was awesome. When you put a face to a name and just say, "My kids are autistic."

So, we put a video together with [AASCEND]. I don't know if you're familiar with them? [AASCEND] is an organization that deals with autism. The president is Camille Baxter, she sits in our work group. When we put this video together, she was invited to come and be part of the CIT work group because we thought that that was an important population in the community. She also be represented in the training, because autistic kids, they might have some symptoms that an officer might interpret as a mental health issue, but there's a difference. Like they respond like they like your pen, and they might [unintelligible] to the pen, or if they like the Star, which they're attracted to shining objects, some of them, autistic kids are. So, they might just try to...and you feel like, "What the hell? He's attacking me, assaulting me." Right? But he's just attracted to the shining Star.

They look away when you're talking to them, because they don't have developed social skills as the other kids do. So, they might interpret it as, "Uh, he's lying to me. I'm asking

him questions," and you know. If you look away from an officer, they go, "What, are you trying to make up a story or something?" So, we do that. We teach them that, hey, there's autistic kids that might look away from you. That doesn't mean that they're lying to you or they don't want to make eye contact, right, which is [an action] with the symptoms that they're deceiving you, but it's part of the illness and stuff like that.

INV. STONECIPHER: Okay.

LT. MOLINA: So, that's medical as it can get.

INV. STONECIPHER: So, you touched, talked a little about this, psychotropic drugs and side effects. So, how is this topic taught, in regards to psychotropic [drugs and stuff like that]?

LT. MOLINA: Just a lecture. A lecture by [redacted], she's the psych nurse from PES.

INV. STONECIPHER: And what drugs are discussed in this topic?

LT. MOLINA: Prozac, Haldol, it's just [unintelligible] drugs, and she recommends the app to the officers, because you know, you're not the [greatest] at things, so you might have a reference, and you download the app, and you put the name of the drug that you see, and then it will give you [inaudible].

INV. STONECIPHER: Now, do you discuss drugs that are like common on the street typically?

LT. MOLINA: Like the most prescribed drugs, like she talks about it, just [unintelligible]. So, she will talk about Haldol, she will talk about Prozac, and I can't remember the other names, but she will talk about it and the effects of it.

How it affects, you gain weight. You gain a lot of weight. You also have sexual dysfunctions when you're taking drugs for mental health. You might become suicidal as a side effect, because the drugs, while you're going through the process of taking it, might make you suicidal for a little bit.

So, she talks about that, and sometimes, the drug is not the right drug for that person. So, you have to experience it, and it takes about 60 days for the drug to take effect. So, just because I take a pill today, I'm not going to feel better tomorrow. It takes 30 days for the effects of the drugs to actually build in your brain and connect whatever it is, to connect it. So, it's a learning process. And that might not be the right dosage, that might not be the right drug, so, you've got to start over again.

So, when you're dealing with a person with mental health issues, we tell the officers you can't just go, "Just take your drugs, you'll be better. Or take your medicine, you'll feel better," it doesn't work like that. So, you have to create that atmosphere where you're not telling the person...be sensitive to what's going on.

INV. STONECIPHER: Now, are officers taught, are there like any signs or clues that they need to look for to maybe indicate that maybe someone is under the influence of like medication or any kind of psychotropic drugs?

LT. MOLINA: Not really. We just talk about behavior, because the behavior can be the same. Like you said, it can be the same. She talks about symptoms, but I cannot remember exactly what each drug...I'm not the expert on drug behavior, so I

can't tell you.

INV. STONECIPHER: Now, once an officer identifies someone who is under the influence of like a psychotropic drug, what steps are they supposed to take?

LT. MOLINA: First they will be safe. Right? What is this person doing that he or she needs to be restrained? Call the medics. Obviously, you're going to have an ambulance standby. If he or she needs to be restrained, then use restraints, but you can use handcuffs until the medics get there, and they have the soft restraints that they put on people, a four-point restriction, restraint on the gurney. If they're going in and out of consciousness, you want to put them in the recovery position. Which is don't put them on their stomach, don't put them on their back, you put them on their side, so the breathing is easier, especially with somebody who is in excited delirium or somebody who has taken drugs.

This is something that is not only taught by the people that come in our class, but also by the Academy. I remember that training, you know, first day and First Responder stuff, so it gets done twice. So, I know [redacted]a talks about excited delirium. There is a small window that the person might be compliant before everything becomes a blur, because the drug is taking over their body. Like if you use PCP…like I work in the Mission District, and back in the '90s, the PCP [goes a little] high then, and you see people that use drugs, take their clothes off because their body temperature start elevating. And that's basically what kills them, the brain gets fried, and the heart bursts out, so they start taking the clothes off.

So, you've got to see what's going on. Their body temperature, they're very hot, and all they want to do is just get away, because obviously, they're burning up. So, it's stuff like that, and that's what we tell the officers. "If you're seeing symptoms like that, call the ambulance," because that's beyond you. There's not much you can do for this person; the medics have to come in and give drugs. And also, OD, overdosing on drugs. You know that's something you look for. Right? I've gone through a few of those, and when they use Narcon, you're likely to see this person just jump back up, like "Wow. He was almost dead, and all of a sudden, he's like…it works. Right?"

So, stuff like that, but it's separate training also, but in our class, like I said, Bush is talking about excited delirium, and how you need to provide aid, if possible. Right? And obviously safe, because they've developed this human super-strength that it takes three or four officers to calm somebody down or to subdue somebody. So, as soon as you have control of that person, put them in the recovery position. Yeah, so, that's the best thing you can do until the medics start using other type of drugs to combat whatever [inaudible].

INV. STONECIPHER: Now, the topic of juvenile mental health, how is that topic taught?

LT. MOLINA: Okay. So, we have Doctor [redacted], she is a well-known psychologist in San Francisco. She is an expert on brain trauma and brain development. So, she does a portion of brain development from birth to early adulthood. She talks about trauma, and how the brain grows, and what parts of the brain works as a teenager. Things are not

connected all the way and explains the behavior. And she also talks about PTSD, within kids that has experienced abuse; drug abuse or physical abuse. She also talks about the neighborhood, how that affects juveniles growing up.

So, anybody who's planning to have kids, you [have to have] her class. It's two hours and she talks about abandonment, and how a 25-year-old might be acting like a 12-year-old, when we talk to them; the fight or flight response, all this other stuff. So, it's a very, very good lecture. She's a well-received instructor, and when she's not able to do the class, we have [redacted], she's the president of Hunters Point Family. Basically, she comes and talks about toxic trauma. What it's like to grow up in Hunters Point area, Bayview District, and how the violence, drug abuse, and so forth, affects kids growing up. So, those are the two topics that we address as a juvenile.

INV. STONECIPHER: Okay. And what about geriatric mental health? Who teaches that topic, and how is that taught?

LT. MOLINA: UCSF. We have a [directed] program that they come in and do two hours. One is an interactive section, and the other one is a lecture. So, I want to say it's Doctor [redacted] the main contact. So, for about an hour, we talk about how we're all growing old, we're all getting there. Talk about dementia a lot. You know how you get to have dementia and how to identify some signs and symptoms of dementia. And we also do an hour of exercises.

So, we have kits that we put together. We separate officers, I think it's four groups. So, we have the officer put gloves on and then try to button their shirts with gloves on,

and that simulates arthritis, how hard it is to move. We also make them walk…we tie their ankles. We put a band around their ankles and we will give them a cane, and they have to walk to simulate also, arthritis in old age. Right? People don't move as fast as they did before. We also use glasses that have pinholes in it, simulating glaucoma, cataracts, and we ask them to put pills in one of those pill dividers for the week. Like you'll have Monday, Tuesday, Wednesday, they have to identify the pills and put them in the right place. So, it's a practical exercise. So, we make them walk in that person's shoes.

We also have them do tasks with those tools like old people, like me, myself, have to tie their shoes. You know, they cannot get all the way down, so they use like a little tweezer thing, and they have to tie their shoes using the tools. So, what we want to accomplish is having the officer understand the process when they're dealing with somebody of old age. There's a saying, you've got to give it time. They're not as fast as we used to be, and you're dealing with, my line to them is, if you're dealing with the person, think that that's your grandmother or your mother. And if you treat that person just like that, unless the person is attacking or hitting you, doing something, or attacking somebody else, then obviously, you're going to have to use restraints. But if it's a person that you're trying to calm down, or you're trying to find out what's going on with him or she, then imagine an old relative of yours that you like or you love, and then you will find the right answers for everything.

INV. STONECIPHER: What about the topic of family

perspective by the National Health Alliance on Mental Illness?

LT. MOLINA: NAMI.

INV. STONECIPHER: I guess the question is…

LT. MOLINA: Yeah, I answered that one.

INV. STONECIPHER: Yeah. And the topic of suicide and suicide intervention, how is that topic taught?

LT. MOLINA: So, we had San Francisco Suicide Prevention, [redacted] is the main contact for that. So, they come and talk about statistics in the beginning; we know about suicide. Then they get into their program and how they deal with phone calls, and how they would get the police department involved if they feel like it's out of their reach, and the person's still very suicidal, or if there's a weapon involved. So, they talk about the process, how they contact the police, and keep the person on the phone until we respond to it. They also do two exercise. They split-up the class in two. There's usually two instructors. One stays in the classroom and the other one goes to a separate room, and basically, the instructors play the role of a suicidal teenager who has taken pills and has consumed alcohol.

The officer has to make that suicidal person, first of all, build a rapport. Basically, that's what we want. Reflect emotions, don't judge. So, we do that. It's a two-hour segment, and we talk about the best, to create a plan. Right? Before you leave, you make sure that the person is safe. If they need to be 5150, which usually, that's going to be the case, right, we don't leave suicidal people. We don't go, "See you later." No, we don't do that.

But if you're there already, so you have to develop a plan. You talk to the family, especially if it's a juvenile. You find the resources. You call child crisis, and they're the ones that come and decide where the kid is going to go to. If it's an adult, you take them to PES.

INV. STONECIPHER: And what signs or clues are officers taught to look for to identify this is an issue that you're dealing with? Someone who is suicidal or you know, suicide is definitely [unintelligible]?

LT. MOLINA: You ask. You ask, because it used to be a myth. People thought if I asked you, "Are you suicidal," it's going to induce you to commit suicide. That used to be the myth, but research has shown that no, actually, you got to ask the question. Because somebody might not say I'm suicidal. They'll say, "I don't think I'm going to be here tomorrow." Or I'm giving stuff away, I'm making phone calls and saying good-bye to people. Or they say, "I'm going to hurt myself." Well, hurting yourself can be pinching yourself, it can be something.

"So, what do you mean that you're suicidal?" So, we ask that officers go straight to it. Don't go around it, don't try to sugarcoat it, just ask the question. "Are you feeling suicidal today," and see what they say. Now, I think, someone's actually reflecting what they're going through, and that will establish a better rapport, so we do that. Those are some of the instructions that come out during the class. Be direct and people will talk to you, and once you pass the hump, it's like, "Okay. Now I've said it. Let's see now, how we can help you with it."

INV. STONECIPHER: Now, the topic about dual diagnosis. How is this topic taught?

LT. MOLINA: That is [redacted] too, mental health science and symptoms. Because what we learn from talking to PES…and this is just from my experience with the program, because I have met some other people that work with [them], and talking to other doctors, in San Francisco, one out of two persons that are taken to PES is high on drugs. So, our focus is, like I said before, the symptoms might be the same. They might come out as the same, but it might be a chemical-induced psychosis, because of meth, cocaine, heroin, whatever the person has taken, or a combination of drugs that they've taken, plus psychiatric pills. So, not only, you have chemical induced, but also mental health stuff too.

So, we tell our officers not to diagnose again, not to try to assess what the person is, but just to deal with the symptoms, and let the medics decide how they're going to deal with it.

INV. STONECIPHER: And again, just to clarify. What is dual-diagnosis?

LT. MOLINA: It's having two…a person who is using drugs and he's also, at the same time, might be mentally ill. So, but we also tell the officers, "Hey, they might be using drugs to self-treat, because they're not taking the medications, the mental health medications." So, they're using the drugs to self-treat themselves. So, you've got to address that with the doctor. [redacted] talks about it and says, "Hey, we got to clear them up. Get all those chemicals out of their body before we can

assess them for organic mental health stuff." So, you cannot do treatment. Basically, that's what tell you, "You cannot do treatment on mental health unless the person is clear of any drugs."

INV. STONECIPHER: Now, again, are there any signs or clues that officers are taught to look for to identify this [condition]?

LT. MOLINA: Just the same, because like I told you, the signs are usually, present the same.

INV. STONECIPHER: Now, the topic of vicarious trauma, how has this trauma been taught?

LT. MOLINA: We talk about how you get affected by us. By going, especially to us, right, seeing victims of stabbings, seeing victims of shootings, reading police reports, testifying about crimes, seeing dead babies, seeing kids get hurt and stuff. We have a section on sleep deprivation. It talks about self-care and how to identify vicarious trauma, because if you're not right yourself, you're not going to be able to help anybody else, and how to watch out for signs like that.

INV. STONECIPHER: And again, just to clarify, what is vicarious trauma?

LT. MOLINA: Vicarious trauma is something that affects you by just the mere fact that you were exposed to it on a daily basis or on a continuous basis.

INV. STONECIPHER: And who teaches this topic in the program?

LT. MOLINA: Well, there was two different instructors. In the beginning, [redacted] touches on it, because it has

to do with the brain. We also talk about PTSD, Doctor [redacted] talks about exposure to different incidents, especially veterans, police officers. Who else talks about vicarious trauma? [redacted], who is also a psychologist and retired police officer from San Raphael.

INV. STONECIPHER: Now, are officers taught, again, are they taught, are there any certain things that they were taught themselves to look for, to let them know that they were kind of experiencing this, or might be going through this themselves?

LT. MOLINA: Well, just be aware that this might happen. And obviously, when it comes to officers, there's a confidentiality issue with it. So, there's actually, "Uh, this is what I experienced." It doesn't happen like that, but at one point, we used to have BSU used to come in when I was there, because I was the head of the unit. I think I felt like officers should have a section of self-care, and we'd talk about vicarious trauma, alcohol use by officer and drug use. That stopped as we implemented like the new self-care. We do Awaken the Warrior, it's called, about sleep deprivation, that talks about some of this stuff too, and what we do. How we deprive ourselves of sleep as a First Responder. So, we stopped BSU, but then we had that two hours of self-care.

INV. STONECIPHER: Okay. Now, that was actually my next question. So, the topic of self-care. Is that taught inside, coincide with vicarious trauma, how that's taught as well or is that separately?

LT. MOLINA: Yeah. You know, honestly, vicarious trauma, most of my mental health instructors will touch on it, because

it affects you. It's part of the brain trauma, brain development and stuff. So, not per se, it's like a block on vicarious trauma, but it gets touched by different instructors during the week.

INV. STONECIPHER: And who teaches the topic of self-care?

LT. MOLINA: Self-care is Psychologist [redacted] [redacted]

INV. STONECIPHER: And what is the [unintelligible] to self-care, and how does that relate to policing?

LT. MOLINA: Well, my main focus is like you've got to take care of yourself to take care of others, that's it. Right? If you have a happy officer, you have a happy worker. You have a person who's going to go and help the community that they need to protect and serve. So, we also talk about how this job makes you cynical. It does, because you see the same people over and over. You've got to keep arresting the same person, or you're dealing with the same family over and over, and you don't see any changes, so you're like, "What's the use of having this? What am I here for if nothing's going to happen? Why am I taking this report if the DA's not going to file charges?" So, we bring them back on how to find themselves in situations where it seems like things aren't going to change, but if you keep doing your job, it might change at one point or another. So, keep doing what you're doing, don't dwell on the negatives, dwell on the positives. So, that's why we also brought the nobility of policing with Captain Hart, that's how we started our program. We bring them back to, why did you become a police officer?

INV. STONECIPHER: And what is the substance of this

training for self-care?

LT. MOLINA: As far as?

INV. STONECIPHER: I guess, what exactly is taught? Is it just, are they taught certain things to like them to help them take care of themselves mentally? Like what they can do?

LT. MOLINA: Yeah, develop a hobby. Right?

INV. STONECIPHER: Yeah.

LT. MOLINA: Have time to yourself. We ask officers to…and this is the BSU part of it. If you can, find a therapist. Find somebody in your corner that is willing to listen to you without judgment. If something is affecting you, [your way of living off the job], obviously, it's an issue. So, you've got to address it, because if you don't, you're going to find yourself in the bar down the street right after you get off of work or before you come to work, because you're going to numb yourself, so you don't feel the pain that you're having.

We also talk to the officers about identifying signs from their partners. Active listening like, "I'm tired of this shit, man. I don't know if I want to do this anymore?" We have a peer support program. Maybe you want to talk to somebody. We have the BSU therapists, we have 30 therapists that [have been] in the police department. And they don't have to tell anybody. They can just pick up the phone, call, and just say, "Can I get an appointment?" So, it's very confidential stuff, but we encourage that. You don't have to tell a supervisor. An officer doesn't have to come and tell me, she or he can do it themselves, and seek help before it gets out of hand.

I always make the analogy of triple-A. Don't wait until the

wheels fall off. Make that phone call, we'll come and change the tire and get you back on the road. Don't wait until the four wheels are off, because then you might be in trouble already. So, we do that, so that's the main substance, to make the officer aware of he or she is going through.

INV. STONECIPHER: Now, what about the topic of conflict resolution. How's this topic taught?

LT. MOLINA: As far as verbal de-escalation?

INV. STONECIPHER: Yeah, just in general.

LT. MOLINA: Yeah. I mean it's mediation. Right? Don't take sides, listen to the facts, listen to people's emotions. Don't listen to the [contact], because the [contact] is just going to misguide you through, and it's going to create some type of reaction that you don't want. So, listen to the contact, reflect emotions, and as a police officer, I mean, we're not judges. You got to go by the facts, and whatever the facts or the evidence is pointing to, you go with it.

In a situation with conflict resolution, obviously, your main goal is to resolve the issue peacefully, without the use of force if feasible, but we also tell them, "Hey, there might be situations that you might have to go hands-on." Like you're trying to calm somebody down and the person is just too agitated. You try everything, you let him pace, you let him vent, but the person is still number five here, and you don't know what's going to help him to come down. Then he or she might have to be restrained, so you have to plan for that.

INV. STONECIPHER: So, that's taught inside of verbal de-escalation?

LT. MOLINA: Yes, the de-escalation process, yeah.

INV. STONECIPHER: Now, what about the topic of suicide by cop? How is that taught?

LT. MOLINA: That is taught by [redacted], who is a nation expert on suicide by cop. It used to be, back, before 2015, it used to be [redacted] used to do that, and she was a professor, I want to say somewhere in the North Bay. She was our expert on suicide by cop for the police department back then. She will come in and talk about how to identify suicide by cop, because sometimes, it's very masked. Like pretty much the same topic, I remember with [redacted] now, is we look for…if you're responding to a call—this is for instance. You go into a bank robbery. You know the person who's committing, the suspect is going to go in, rob the bank, get away.

Now, you're responding to this call or any type of call, with that [unintelligible] violence or aggression, so you respond, and you find the person in the parking lot, like waiting for you, that might be an indicator of, "Why is he here?" Right? Because a suicidal person is going to force your hand into confrontation. They're waiting for a police officer to actually finish their suicide. So, you look for that, you look for a countdown. When you look at suicide by cop videos, you see the person going one, two, three, and then you force the confrontation with the officer. They might have a fake gun, a toy gun, and they might have it in the waistband, and doing this, and doing this, and the officer, "Take your hands off your pocket. Don't touch the gun. Don't touch the gun." They might just simulate that they're going to do it, so you use deadly

force.

So, basically, that's what you're looking for. You're looking for a person that their behavior doesn't go with what's going on, because he is trying to force you into that deadly confrontation.

INV. STONECIPHER: Now, how common is suicide by cop in policing?

LT. MOLINA: So, it's about 35 percent. So, the national average, according to the FBI or statistics, they're saying that all law enforcement officer shootings, about 35 percent, I think, suicide by cop. San Francisco PD did a study, [unintelligible], SFPD OIS, Officer-Involved shootings, it will come up and go look, and they looked at 15 shooting that we have from 2005 to 2009, and I think there were four incidents out of those 15 that were deemed suicide by cop, which is the average, 35 percent. We're kind of much in-tune with the nation, with the shootings, either because of something that the suspect said prior to the arrival of the police, or something that the family said prior to arrival of police, or during the confrontation, you can tell that a suicide by cop was about to happen.

INV. STONECIPHER: And again, are officers taught that there are any clues or signs to look for to kind of make them realize they might be walking into this type of situation?

LT. MOLINA: Yeah. It'd be like [an odd] behavior. Right? Like once again, if you commit a crime, you're not going to wait for us to get there, like why is the person standing there? Besides they might have lost their ride or the person that was with the person took off and left them. Yeah, that's a

possibility, but an odd behavior. Why is this person confronting you or simulating a weapon? Like they're going and reaching back, reaching back all the time, or pretending they have something. And now, the officer is like, "Okay. What's under that shirt? Let me see your hands." Right?

So, if you're seeing that behavior, what we're saying to our officers, "Create time and distance. Get behind cover. Continue to give instructions," because you don't know. That might be a real gun, because suicide and homicide are just one second away from each other. If this person has decided that they're going to die that day, and they're going to take as many guys or gals with them as possible, you might be confronted with that too. So, you might start thinking of suicide by cop or [else something] you get shot at, because that person decided that he's going to take the first cop that responds.

So, it might be a suicide, but at the same time, it can be a homicide. So, it's very tricky, it's not black and white, but it's also be aware. The best approach would be to create time and distance, get cover. Get cover because you don't know basically.

INV. STONECIPHER: Now, the topic of PTSD signs and symptoms, is that taught from the perspective of officers dealing with PTSD, or is dealt with mainly you're engaging a person who you think is suffering from the side effects of PTSD?

LT. MOLINA: You're engaging with a person that is suffering from PTSD.

INV. STONECIPHER: Okay. And how is this topic taught. Is it done lectures?

LT. MOLINA: Lecture, videos, interactive. [Unintelligible] Doctor [redacted] was teaching it, he works for Palo Alto University, he's a professor there, and he's also a doctor that works with veterans. He assisted in creating some of the programs. There's an app called PTSD coach that you can download if you want. Basically, it's a great app, because you can look into it. We just started recommending that to the officers, so back, prior to 2015, that wasn't available, because the officers didn't know about it. So, it's an app that's a self-test for yourself, it's confidential and stuff, but it also has resources.

So, Doctor [redacted] talks about two-and-a-half hours on PTSD, shows videos from the work in Iraq and Afghanistan. Talks about hypervigilant and how the veterans come back here, and some of them are affected by it, and some of them are not. So, that's the tricky questions. Right? Like why is PTSD affecting some of our veterans and some are not? What's the process? Why one gets affected and the other one doesn't, when they went through the same situation? So, he talks about that.

He says there usually is the reaction people have to trauma. He shows a video of two guys in a Humvee. They're driving behind another truck and an IED goes off on the road, and one guy just starts yelling and screaming, "[Unintelligible]," and the other guy goes, "Damn, that could have killed the truck in front of us." He goes, "When I hear that, I get worried, because that's a straight denial. It could have killed you, dude, but he doesn't talk about that could have killed me." So, obviously, he's reflecting what just happened to

him, because he doesn't want to internalize. He says, "Uh, shoot, I almost died." So, he says the guys in front of us almost died; I'm safe.

But some of the stuff that they have developed, research...I'm not an expert on that, but he talks about that, of how reactions to an incident can be so different. So, they're still [unintelligible] of how PTSD is regarded, but he talks about that. He talks about our tactics also. A veteran might interpret tactics differently. You're familiar with police deployment. Right? If I'm cover, I'm contact, and a veteran that knows what you're doing, might interpret that as he's about to get ambushed. If he sees an officer talking and the other one triangulating, right, that's what we're taught, to triangulate. So, he might interpret that as, "Uh, shit. Those cops are about to ambush me," so, be aware of that. So, he talks about all the different things that we should be watching out for veterans, and also, how to identify a true veteran, [not somebody who just made it up], so he talks about that.

We also had [redacted] comes in and talks about veteran services. She works for the Veteran Court. I don't know if you guys know, but we have a Veteran Court here. Like if you're a veteran and you commit a crime, you don't go to the regular court, you go to Veteran's Court, and there's a special pod in CJ just for veterans. So, she comes in and gives out cards, because her job is to connect people, it's outreach. If you encounter a veteran, you call her, and you tell her who the person is. She will look him up, whether it seems true he is a veteran, and she will go out, or she will go out to the jail and

try to get this person services [inaudible]. So, it's a very comprehensive, almost three hours, on veterans.

INV. STONECIPHER: And again, just to clarify for the record, what is PTSD?

LT. MOLINA: It's Post-Traumatic Stress. So, you were exposed to an event that somehow got imprinted in your brain, and you tried to relive that event based on things that you saw, or heard, or that you smell. You have five senses, so just about when certain things are about to happen and it happens in front of you, your brain registers that. You can remember the smell. You can remember the sound...let's say a car accident, in front of you, a pedestrian getting hit by a car. You see that person walking in front of you, not looking at what's going on, but looking at the phone, and all of a sudden you see [hear], (snaps fingers), it's gone.

The brain start, "Okay. What just happened here?" You hear the brakes, you hear people screaming. The smell, maybe somebody is selling a hot dog or whatever, so all this stuff gets imprinted in your brain. Now, everytime you hear a screeched tire or something, you relive the incident, or you smell the hot dog that was being sold at that time, your smell, it's all imprinted in your brain, that's to keep you from getting hurt. Your brain creates this footprint that says, "Hey, you're about to die. You almost died. If that would have been you, you would have been dead." So, we're going to keep you from doing that. So, the next time you smell this, you'll be hypervigilant that something bad is about to happen.

That's what we call flashbacks. They get triggered by

flashbacks. Like veterans, they hear like the 4th of July, or when we had the Blue Angels here, and they hear those planes going, soaring over the city, that might create a flashback. So, he teaches a technique to bring people back that's very effective, if you, as an officer, are responding to a person who is having a flashback. What he does to [connect] with us in the classroom, he shows videos of 911 with very somber music, and you see the planes hitting the two towers. Obviously, your reaction is you get pissed.

I know if I were to ask you...like he does ask us, "Where were you on 911?" You will start thinking about it, you exactly know where you were. If you remember where you were in 911 when you found out about the towers, you will relive it in a second, and you will feel sad, and you'll feel angry because of seeing all those people dying. So, what you do is, you tell the person, "Tell me something that you see in this room," and then you start thinking about it. "Tell me something you hear in this room. Tell me something new that you see in this room," and that will bring you back. So, that technique is very effective with bringing somebody back from a flashback, so we teach that.

INV. STONECIPHER: Now, are officers taught what signs and clues to look for to identify that this is an issue?

LT. MOLINA: Yeah. I've seen situations like that, crimes.

INV. STONECIPHER: And does that coincide with the topic of veteran encounters and interactions?

LT. MOLINA: Yes, it's the same.

INV. STONECIPHER: Okay. The same thing?

LT. MOLINA: But prior to 2015, I'm sorry, prior to 2015, we had a chaplain from Campbell that used to come and talk about veteran interaction, because he was a veteran himself, and he will come and talk to veterans. Almost the same thing, it was a little repetitive, so we stopped it because we felt like he was overlapping with what Doctor [redacted] was teaching, but that used to be part of a topic.

INV. STONECIPHER: And again, was this the same instructor...for veteran encounter interactions, was this the same instructors that were also teaching stuff on PTSD?

LT. MOLINA: [redacted], yes.

INV. STONECIPHER: And what about the topic about homeless outreach? How is this topic talked about?

LT. MOLINA: So, that was 2015. It used to be sometimes [redacted] who used to come and talk to our officers. Also, she would send somebody from her office to talk. There was a little bit, I wouldn't say friction, with the information that they were providing to us was less than accurate, because cops deal with homeless. Right?

INV. STONECIPHER: Uh-huh.

LT. MOLINA: And her numbers of the San Francisco residents or San Francisco natives didn't match with what the officers know on the street. Like they're dealing with transients all the time, but she will say, "No, there is 6,000 or 3,000 homeless children in the city." And we're like really? Well, how do you know that? Okay. So, these stats that they were producing to us, were self-acquired stats. They'd go out and talk to somebody, and whatever they said, that's the stat. So,

we're like, "Okay. That's not scientific, that's kind of subjective and kind of fits your intentions."

So, it's a big class. We were more focused on resources. What we wanted was resources. Obviously, she's a big activist. She's not an advocate, she's an activist in the city, and that sometime came across in the class, but she managed herself, and the officers were very polite, and went back and forth. We agreed on disagreeing sometimes, because we didn't feel like her stats were in-tune, but still we'd talk about it. We haven't taught it since 2016. We do touch about homeless and other resources through the presentations from the panel, because some of the people, the consumers that come and present to the officers are homeless.

INV. STONECIPHER: And how is this relevant to CIT or policing in general?

LT. MOLINA: My gosh, mental health and homeless population? We believe that at least 70 percent of the people that are taken to be as homeless, so it goes hand-in-hand. You talk about do a diagnosis, and you add homelessness to that, [unintelligible], mental health, and now homelessness. And usually, homelessness can also create a mental health issue. Can you imagine sleeping on the sidewalk every night, only on cardboard? You have no sense of security whatsoever, like you have at your house when you go and you sleep in your bed or your bedroom, and everything. These people are sleeping on the street.

Anybody can just take that cardboard off, and now you become a victim, especially females. We're dealing with some of

that stuff in my unit, on how they're getting raped and abused on the streets because of this homeless stuff, encampments and everything. So, definitely go hand-in-hand. They don't sleep well obviously, because they [unintelligible] at night; can't go to sleep on the sidewalk. So, we definitely, it is a topic that is addressed.

INV. STONECIPHER: Now, how does it work when an officer needs someone from the HOT team? Like what are they to do?

LT. MOLINA: Okay. So, I've done it myself. So, basically, when I was walking Market Street in the summer, we'll talk to the person, find out what the needs are, and whether they want to go to a shelter or not, or if they have any resources. If they say yeah, we'll say, "Do you know who the HOT team is?" And they say, "Yeah, yeah." "Do you want to go with them? They'll take you to a shelter. They can take you to a place where you can take a bath. You can get a meal," and they'll say yeah.

So, we'll get on the radio and we'll call Dispatch and say, "I've got Johnny Willis here, and he's a black male, 35 years old." Sometimes they ask for their birth and sometimes they ask for last four numbers of the social security. Don't ask me why, but that's the policy. And they will say, "Okay. We'll contact the HOT team. 20 to 40 minutes ETA." We give them a description of the person. If it's feasible, we'll stay with the person, but if we have to go somewhere else, and the person says, "I'm going to wait for the HOT team to come," then they just stay there. Then we just say, "We'll, he's going to be standing at Mission and 5th, and he's in the southeast corner near the liquor

store." And that's the information that gets, and then the HOT team will come in response.

Now, because they have the new program, they add [unintelligible]. I don't know if you're familiar with this? It's a new program now that the Department has with the Department of Public Health and DEM, that you have HOT team, DPS peoples, and [unintelligible] specialists they call, they go out together. So, now, not only they getting resources from DPH, but they're also getting resources from the HOT team.

INV. STONECIPHER: Now, based on what we just talked about, all these different topics that are taught throughout the CIT program, did you help draft like these specified policies and procedures? Like, okay, this is going to be the substance of CIT? This is how we want it to work?

LT. MOLINA: For the polish, it actually was your lawyer who did most of the work; [unintelligible]. We met down below, I think it is, where we met last time in that room?

INV. STONECIPHER: Yeah.

LT. MOLINA: It was [unintelligible] from your office, it was [redacted], who else did we have? Sometimes I have Commander O'Sullivan with me, who was my boss at the time. I think [redacted] will come in. It was a representation of the work group, the CIT work group, but [unintelligible] was in charge of the drafting. She would do the draft, send it out to us, revise it, do it again, revise it. So, it was a collaborative between the PD and DPA.

INV. STONECIPHER: Okay. So, there are a couple of Department bulletins, or a few Department bulletins I just

wanted to show you. I just want to see what the correlation was between these bulletins and the CIT program.

LT. MOLINA: Sure.

INV. STONECIPHER: Let's see here. So, this is Department bulletin 16-060, this is the Use of Service and Support Animals by Persons with Disabilities. So, take a look at it.

LT. MOLINA: Right. So, you'll find this on my website for CIT, I put them in the website. Basically, these are associated. Obviously, a person that has disabilities who needs therapy or a support animal is associated with mental health, right, at one point or another. So, we put that as a reference for the officers, it's research and stuff, I guess, [inaudible].

INV. STONECIPHER: Now, how does this Department bulletin relate to the CIT program that is taught?

LT. MOLINA: It's other resources and guidelines for the police department policies. Right?

INV. STONECIPHER: Got you. Now we're going to take a look at, this is Department bulletin 12-085, Operation Outreach Program Call for Processing Homeless People, Bag and Tag. Just take a look at that and just kind of let us, again, describe how it's related.

LT. MOLINA: Yeah. It's the population that we deal with. As I said before, according to PES personnel, about 70 percent of the people they see are homeless.

INV. STONECIPHER: Okay. And then this is Department bulletin 12-165, Reporting and Investigating Suspected Elder and Dependent Adult Abuse. So, again, if you just want to talk about

how that's related to the CIT program?

LT. MOLINA: Yeah. It's a policy related to CIT. We talk about [unintelligible] Program and it talks about dementia and what to look for. So, that's something that we've got to associate with mental health.

INV. STONECIPHER: Okay. And this is Department Bulletin 13-120, Response to Mental Health Calls with Armed Suspects.

LT. MOLINA: So, this is obviously, prior to the policy. This came out in 2013. Right?

INV. STONECIPHER: Uh-huh.

LT. MOLINA: And that was something that was created before I came onto the program, but it was specific information, how to respond to people with weapons.

INV. STONECIPHER: Okay. Again, how are officers trained to identify like a quote, "A mental health crisis"?

LT. MOLINA: As we were saying before, it is not a black and white situation; police work is not black and white. Basically, CIT has guidelines and the officers are taught, they are given tools on how to respond to a call, but we said, "Hey, it depends on what you have." It depends on if it's feasible, too. So, if you respond to a crisis...and I explained that before. You have to evaluate everything you're getting. We also, right now, we're teaching them, "If you don't have enough information, if you don't feel like you have enough information, and you have time to get to your cellphone, call that number. You see it on your screen in your police car. You have access to the information, make the phone call yourself and call whoever is calling you."

INV. STONECIPHER: Now, in that Department bulletin, I think it references a supervisor.

LT. MOLINA: Yeah.

INV. STONECIPHER: So, this supervisor that officers are supposed to contact, is that a patrol sergeant? Is it a higher-rank officer? Like how specific is it if they need to contact?

LT. MOLINA: So, this has been superseded.

INV. STONECIPHER: Okay.

LT. MOLINA: All right? Because the bulletins are only good for two years.

INV. STONECIPHER: Got you.

LT. MOLINA: So, this is not policy, it's just a bulletin. So, now with 2018, this is five years ago, so this has been superseded. We're not responsible for bulletins after two years, it just went out like that. So, "[Unintelligible] are required to respond to the incident in both the following. Call the number of the person." So, like I was telling you earlier, it makes my day when I hear the calls being put out as 800 with a knife. 800-222, which is a person with a knife, a mentally disturbed person with a knife. And the officers, will [unintelligible] on the radio, if they're CIT trained, they'll say, "3 David 14 David, I'm CIT trained and I'm responding." Supervisors will get on the radio and say, "This is 3 David 110, I'm also responding."

Obviously, the officer can ask for a supervisor to respond. Headquarters can ask for a supervisor to respond, but according to this bulletin, the sergeant has to acknowledge that he's responding. So, there is three ways. It's either the officer

asking for a supervisor, Dispatch is asking for a supervisor, and the supervisors themselves are saying that they're responding. But it says, "You shall [promptly] respond or request a supervisor to respond."

INV. STONECIPHER: Now, you said that was superseded. Can you again, just clarify what it was superseded by?

LT. MOLINA: My understanding of Department bulletins are good for two years, so every two years, they have to be re-issued. If they're not, then they're not valid.

SR. INV. VILLARREAL: Got you. Okay. And I do believe that one was re-issued a couple of times, but I don't know now that we have the new DGO. I don't know if [unintelligible] like this.

LT. MOLINA: The Department policy comes into place, the bulletins don't apply anymore.

SR. INV. VILLARREAL: Right.

LT. MOLINA: So, we still pass this out to our officers, because they've got resources.

INV. STONECIPHER: Okay.

LT. MOLINA: So, resources for them to contact, so we still give them a copy of the bulletins, even though they're superseded. We say, "We're superseded, so you're not responsible for the [content], but you're responsible for learning your resources in your neighborhoods and stuff."

INV. STONECIPHER: Now, is there always a supervisor that's listening to CAD traffic typically or not?

LT. MOLINA: I don't know how to answer that. That's a [unintelligible] question, a DPA question.

INV. STONECIPHER: Yeah. Now, is an order from a

supervisor required to deploy an ERIW or OC spray typically?

LT. MOLINA: I'm sorry, what do you mean?

INV. STONECIPHER: So, in a situation where they're dealing with someone who is, it's a mental health crisis call.

LT. MOLINA: Right.

INV. STONECIPHER: Does there need to be an order from a supervisor or a higher-ranking officer to deploy an ERIW or OC spray?

LT. MOLINA: No. The officer decides. I mean, I can't, as a supervisor…

INV. STONECIPHER: So, they have their discretion on it?

LT. MOLINA: Yeah. Uh, yeah.

INV. STONECIPHER: Okay. Now, when a supervisor arrives on the scene, does that person assume command of the situation?

LT. MOLINA: Well, it depends on what's going on. Right? What we teach is for our team concept, we want the first supervisor to respond, to take control of the team. All right? What's the situation. You have the contact officer, you have the less-lethal officer, the ERIW, and the lethal cover, you have an arrest team. So, you're responsible for that as a supervisor. We want the supervisors to understand that if feasible. If there's other things going on, then you do what you need to do to bring the situation to a safe presence.

So, if you respond and you have control, you team the second supervisor to manage the scene, and the first supervisor will manage the team. That's what we're teaching now, scene control. You respond, you're in charge of the team. In the past, CIT, we didn't talk about that. Prior to 2015, we didn't talk

about…it was given. As a supervisor, you're respond to the scene and you're the supervisor, you direct people as you need them, where it's necessary.

INV. STONECIPHER: Now, if we're still looking at that Department bulletin, I think the Department bulletin states, quote, "Under no circumstances shall officers jeopardize their own safety or that of any person attempting to interpret or ply this directive." Can you just expand on this? What does that basically mean, if you know?

LT. MOLINA: Don't put yourself in harm's way to comply with this if it's not feasible. It's like force options, you don't have to go, "Okay. I try one, I try two, I try three," and it's not working, you can go from one to five, depending on what the situation is. So, we're saying to our officers, don't get yourself killed over trying to comply with this when it's not feasible to do so. You got to save somebody else. You got to save yourself, or you got to save the person from himself. Is there guidelines to me? I know it's Department policies and procedures, but they're guidelines, and they're there to guide you through a process, but they're not the bible that you have to do this, this way. There's a reason why my officer might not comply with this, because it was not feasible, it was not doable. If I would have just followed this, I would have just gone home. What am I going to do here? Right?

So, to me, they're guidelines. Policies are guidelines and procedures that will keep you within the realm of liability and what the Department is responsible for, but sometimes, that doesn't apply, because you have to think out of the box to save

somebody's life or your own life.

INV. STONECIPHER: Now, you talked about time and distance, but can you just explain the concept of time and distance and cover, and how it relates to what the police do?

LT. MOLINA: Well, that's the emphasis on [unintelligible] to save lives. It doesn't matter, everybody. My thing is, everybody goes home tonight, everybody, if it's feasible. Right? So, time and distance. You're responding to an incident, once again, get as much information as you can. Create a plan, get resources there, get a supervisor there if you have the time to do so. But if you arrive to a scene and someone's acting out, attacking somebody, just attacked somebody and is now going somewhere else, you have to have public safety first; your safety, their safety, and the public. So, you have to address that before you can engage in any type of de-escalation.

You've just got to look at what you have. If it's feasible, create time and distance, get resources, call supervisors. Do everything that we teaching you as tools, but if you're going to a call where the person is armed with a weapon, and the person had just committed a crime or is about to commit a crime, whatever the situation is, you have to act to protect life; you have to act.

INV. STONECIPHER: Now, because of the time and distance, how has this changed within SFPD with the adoption of the new 5.01 DGO?

LT. MOLINA: Well, I can tell you, I'm not an expert on the use of force, because I can't tell you how that changed. You might have to ask like Commander Walsh, who's in charge of the

use of force. It goes hands in hands with CIT, because both policies are like married to each other. If your read both policies, you see that almost the same language is being used. Now, officers are required to explain on the reports that de-escalation was attempted, and if it wasn't, why not? That wasn't in the past, in the use of force. Now there's a form that officers have to fill-out, and the supervisor have to fill-out when they use force. That wasn't the case before, so the [unintelligible] changed.

I know for a fact that, in regards to mental health, and this is not exact numbers, but there were over 50,000 calls, mental health related. I want to say 53,000 or so, if not more, but less than 60,000.

INV. STONECIPHER: And that's in San Francisco?

LT. MOLINA: In San Francisco, just us.

INV. STONECIPHER: Okay.

LT. MOLINA: And that includes the [910s], that includes the 800, which is missing person, the 801s, the 806s—a juvenile beyond the parental control, the 800 CRs, the 801 CRs, the 5150s. So, it's less than 60,000, but out of those calls, force was used in only 184, and 111 of those uses of force were just physical restraining a person. So, it has decreased. I know if you put 184 against the amount of calls that SFPD responds to in a year, there were 755,000-plus, we were like 0.0-something, like three or so. So, it definitely has reduced. If you ask me, as the CIT coordinator, I'm going to take the credit.

So, the CIT has helped in reducing the use of force, in my opinion. It has helped the force against officers. If you look

at the first quarter report and the use of report, you'll see a decrease on assaults on police officers, in the use of force by police, and I think, has been going down. So, definitely the training, I think, has changed drastically in the last two years. When we implemented the tactical deployment, I think that's something that was not being done before, and officers didn't have those tools that we're teaching now.

I think that the program has improved. We have gotten better instructors. We have national recognized experts on specific topics. Before, it was a volunteer program, like people would volunteer to go. I know the Department has made it mandatory now, for everybody to go, but now I have people signing up for it, calling me. "Hey, can I get in the program? Can I do this? Can I do that?" So, it has shifted. The view of crisis intervention has shifted across the ranks in the police department. I think it's something people want to do now, which to me, is awesome that we're very much invested in how this is shaping the Department in different ways.

SR. INV. VILLARREAL: I'm just curious. In your experience over time with SFPD and the City, do you think that part of what's happened also, or maybe not, is that there are more people on the street in crisis?

LT. MOLINA: It has increased. It's like this beacon in San Francisco that says, "Come to the City." So, the demand is higher, and I also feel like somehow, we have become very numb.

SR. INV. VILLARREAL: Very what?

LT. MOLINA: Numb.

SR. INV. VILLARREAL: Uh, numb.

LT. MOLINA: Numb to what's going on in our city. If you walk on Market Street, down the street where you guys are at, people don't even think twice about humping over a homeless person sleeping on the sidewalk. Honestly, we have become numb. People just like, it's a way of living now. Shooting drugs in front of City Hall, doing all kinds of stuff, it's just…the City has, in my opinion, a lot of work to do on this. And honestly, looking at what we're doing, I think the Police Department has taken a very pro-active role in doing the training, and teaching our officers, and providing the tools for the officers, because a lot of the calls, like I was telling you, have to do with mental health or person in crisis. When they come in as such on the radio, but when you get there, you feel like, "All right. Does it have to do with drugs or mental illness or some violent crime? But I think, yeah, the City has changed. There's a greater demand for services, so we need to focus.

INV. STONECIPHER: Now, are officers taught that there's a certain amount of time and a certain amount of distance which is ideal when dealing with like an armed subject?

LT. MOLINA: No. It just, once again, it's what you have when you get there. A good example of that was, and we all talk about it, because it made the news. I don't know if you remember the person in front of City Hall, in the Civic Center, on a Saturday afternoon about two years ago? He called up 911 and says, "I'm going to kill the first cop that comes," or whatever. So, he stood in front of City Hall. Can you imagine this? This person is in front of City Hall. You have all the [unintelligible], you have people going to the theater, going

everywhere, and he had a gun in his waistband.

SR. INV. VILLARREAL: I do remember this, yeah.

LT. MOLINA: And cops have to respond to that, and he's standing there. Now, you have this great open area, so what do you do? You have cops coming from everywhere, stopping traffic in every direction. So, you have a square that now, he's in the middle of this square, closest to City Hall. You're putting guns at him, because he's got a gun himself, and he's taking it in and out of his holster, and you're giving him instructions. So, you're getting behind cars now. You have cops here, you have cops here, you have cops here; we're all pointing guns. This guy's close to that guy, this guy's…and then what do you do. Right? So, we like, "Okay, blue on blue," which is our code for we're pointing guns at each other, and start directing traffic, and stop pedestrian traffic.

So, it depends on what you have. It depends on what you have and the situation. [redacted] himself. He [redacted]

[redacted]

INV. STONECIPHER: Now, are officers taught to deal with a situation if someone, let's say, drops a weapon, but it's still within reach? Or are they taught to how to deal with something like that?

LT. MOLINA: Yeah. He still, we have a scenario where officers…obviously, that's not safety, that's not safe at all, where the person has a baseball bat. The team engages the person and then he agrees, if they say the right thing. If they talk about de-escalation stuff and the role player feels like, "Okay. They made the right calls and everything," he will put the bat down. So, he's in a situation where he's got a bat in his hand and he's complying. So, then, "Okay. Are you going to get any help?" said the officer about 15 feet away. He has the bat, but he doesn't drop it, he still has it here. "So, are you going to help me? Are you going to help me? Are you going to help me?"

And then you will see officers that they [kick back] and they keep telling him instructions. They should back it with the ERIW, because he still has the weapon in his hand. All he has to do is do this, and now he hit you in the head. Right? So, we're very specific about situations like that. We tell the officers when you're dealing with a person that has mental health issues, be specific. "Drop the weapon, drop it on the floor." So, a lawyer, or somebody else, when they're making an issue about it, "Uh, you told him to drop it? He dropped it."

So, we go back and teach our officers, and that's when I said the Department has changed, because now we have HNT, negotiators that come and do the role playing. We have tactical

officers that come and assist with it. So, not only do we have the tactics from an expert on SWAT, but we also have the hostage negotiators as role players in evaluations. And basically, evaluation is not, it's like you pass, you fail. It's about explaining the thought process. If we feel like the scenario is going where the officer is using de-escalation, or he reacts rapidly instead of trying to de-escalate, we stop. We ask, "What are you thinking?" You know, "What are you thinking?"

If he give me the right explanation, hey, I felt like you finally stopped this guy from breaking this window. He might have did this, he might have did that. Hey, as long as you can explain the reasons why you did something, that's what we ask. That's what the policy says, explain the reasons why you do something. Sometimes it's not in writing, but you felt like that was the best choice that you had at the time. As you explain it and it is within reason.

INV. STONECIPHER: Now, the scenario we just talked about, was something like that being discussed or taught prior to December of 2016, the CIT program?

LT. MOLINA: No. No.

INV. STONECIPHER: And you talked about it before, but again, just emphasize what is the goal with creating time and distance? Give me scenarios.

LT. MOLINA: For everyone to be safe. All right? So, now you understand that a person that is going through a crisis might need more time, I mean more space to de-escalate than others. So, by creating time and distance, not only are you giving him that, but you're also making yourself safe. We talk

about [exigency] versus efficiency. Like sometimes like if I respond to a call and you're standing there and I'm here, [inaudible] go back and forth. Where do want me to be? Do you want me to be…if I'm holding a bat, where do you want to be in your relationship to me? If you're the officer…we go through this with the officers. Where do you want me to be? How far do you want me to be from you?

INV. STONECIPHER: A lot farther away.

LT. MOLINA: Right. So, and where should you be? Should you be standing by yourself in the middle of the street, or should you be in behind your police car standing? Or should you put a barricade, a garbage can, a chair, here in the room, when you get there? Johnny's going off over there, how far do you want to be from him? But what is the risk? The risk is like, are you getting too far?

We're all humans, and we tend to get closer when we talk to people, so you've got to fight that. We tend to, "Hey, buddy, I'm here to help you," and you start trying to move. What did you just do? You moved in the room when this person's over there. Now you're putting yourself in danger, because all he have to do is go around. Now, that's the door. Where are you?

So, we see this type of behavior, and we're like, time-out. What are you thinking? Why are you putting yourself in that corner over here? You don't have to. Johnny is over there with the knife. You come to the door, you identify Johnny; you see him over there. Why are you going into that room? Stay here. Use the door. "Hey, how are you doing? Police Department." Now, Johnny wants to come out, and [unintelligible], you close the

door. You contain him. Put a chair on it, if you cannot close it.

So, all these tactics are something new to you guys, we didn't have this before, before in the CIT. That's something that we learned by the new training. How to implement, how to change the tactical response to people with weapons. Everything changed after Columbine on active shooters. Right? Go, go, go, go, and stop, stop, stop the [trek].

And now, with mental health issues across the nation, all these high-profile shootings that we're having not only in our city, but across the nation, we're seeing that we don't want our officers to create the urgency. We have policies that say if the person is only a threat to themselves and no others, to nobody else in the room, why are you going into that room? Why are you creating the urgency? Unless it's an urgency where he's saying, "I'm going to set the place on fire," then, now, you've got to go stop him, because there's people at risk if it's an apartment building or somewhere else.

If the person is contained in the room, why are we going in? He's suicidal in the house and says he's the only one there. He says he's got a gun and he's suicidal, why are we going in? We're going to talk this person out of the house, even if we stay there for three or four days, but we're not going in. So, that's the changes. It's the view, because what you see in police work, officers sometimes create the urgency. "I'm going to go save him," and then you ended up shooting the person. So, you're going to go save him and then you shoot him? How does that work?

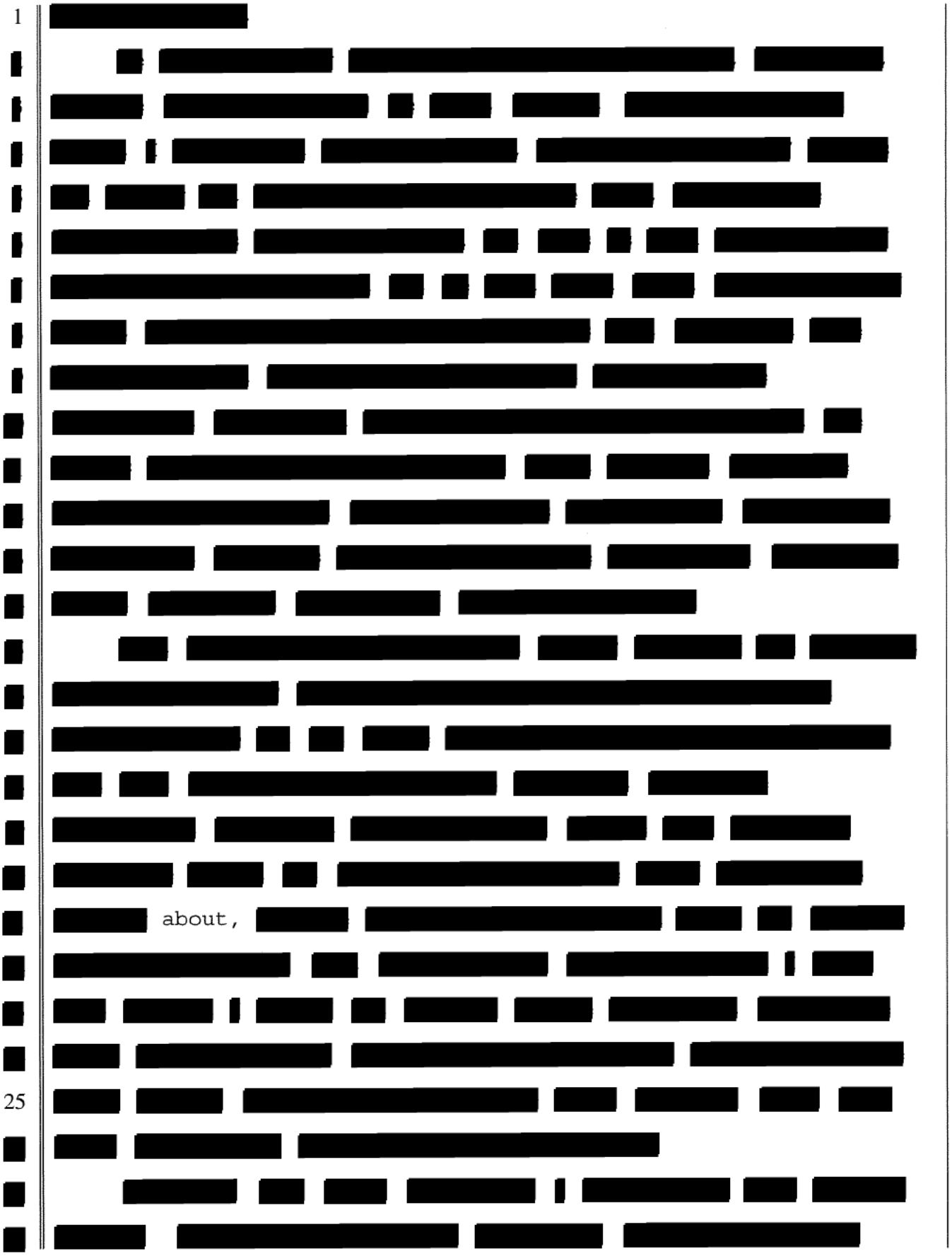
So, we don't want that and that's what we tell our officers. Unless he's hurting somebody, unless he's saying he's going to set the place on fire, unless he says he's got a bomb or whatever it is that you're dealing with, and you feel that you have to go in that room, the you have to go in the room, but you have to ready to explain why you did. What we would like you to do is create time and distance, give instructions, interview people around it. Parents, when you go into a house of a person in crisis, it's not just one person in crisis. The whole house is in crisis obviously, that's why you're there. So, separate them, interview them, get as much information as you can, and talk to the person.

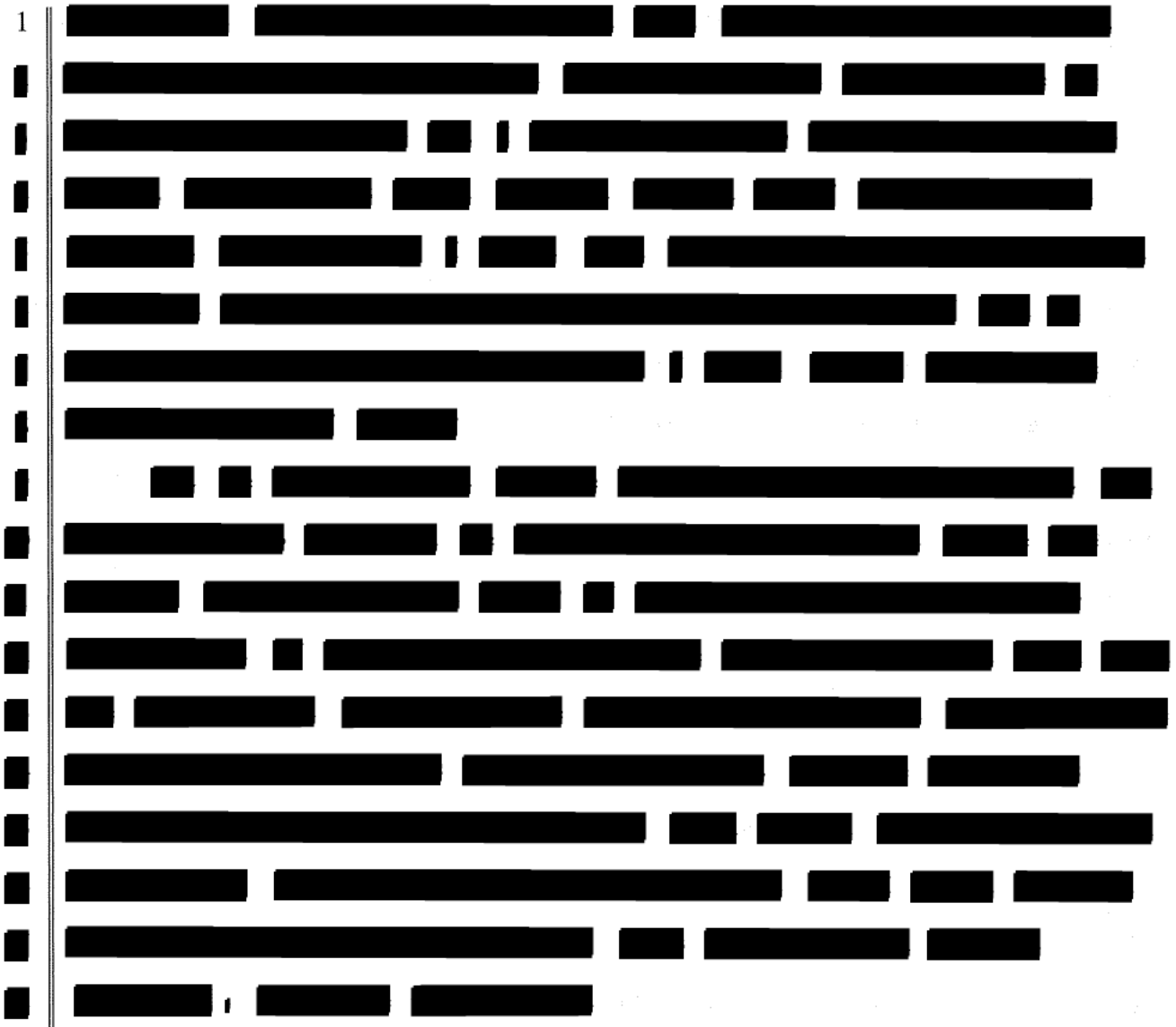
INV. STONECIPHER: Now, we were talking about verbal de-escalation. Now, are officers trained on how long they should engage in verbal de-escalation techniques before finding the effort futile?

LT. MOLINA: As long as it takes.

INV. STONECIPHER: Yeah.

LT. MOLINA: As long as it takes. Yeah, there is no time limit. [redacted]





So, it took us six hours, and it has taken HNT negotiators sometimes two days, so there's no time limit. That's what I'm trying to say, there's no time limit on how we do this.

INV. STONECIPHER: Now, are officers trained with different time and distance de-escalation techniques, depending on the weapon involved? So, are they given different scenarios? Like are you going to be teaching them something different if someone has like an edged weapon like a knife, compared to someone who has like a firearm?

LT. MOLINA: Definitely. Right? A knife, they have to

get close to you to hurt you. A gun, they can shoot it through a wall, can shoot it through a door. So, you're going to approach it differently. You're definitely going to approach it differently. Prior to 2015, that wasn't even mentioned, because weapons were not involved in the role plays. You cannot even touch the role players. So, we changed that, because I said this is not conducive. Right? We're asking our officers to respond to a person in crisis, and we're not addressing this issue. So, obviously, that was being addressed in a different type of training, in the Academy and tactical training for active shooters and stuff, but not in CIT. So, I felt like, you know, we should change this, let's look at best practices.

And I was able to travel to Washington, like I was telling you guys. I went with your ex-director to Washington D.C., and they were talking about different tools that the police department was using, different tactics, and that's how we learned about Seattle. I said, "Well, this is great. This is what we need. This is the tactics that we need to approach somebody with an edged weapon or firearm." It's a whole different ball game when the firearm is involved, especially when you're getting shot at.

SR. INV. VILLARREAL: Prior to 2016, you mentioned a course they're taught somewhere in the Academy, about how to deal with somebody with an edged weapon, and all the other things. Did you have any familiarity with those trainings?

LT. MOLINA: I remember going through the training.

SR. INV. VILLARREAL: [By yourself]?

LT. MOLINA: Yeah. Well, there's a person in the

department that can address those, what they're teaching nowadays.

SR. INV. VILLARREAL: Right. You don't know if they touched on any of the sort of, hey, when you're reading the situation, you also have to figure out whether the person, what their mental state is or anything like that. Not figure it out, you don't even know.

LT. MOLINA: Yeah.

SR. INV. VILLARREAL: Okay.

LT. MOLINA: That's something that you probably have to talk to somebody else about.

SR. INV. VILLARREAL: Yeah.

INV. STONECIPHER: Now, do you teach physical de-escalation tactics?

LT. MOLINA: What do you mean physical? Restraining?

INV. STONECIPHER: Maybe that.

LT. MOLINA: Yeah, we do. We do a wrist control. We do the scenarios and we do a mat session right after the scenarios. One of my sergeants, Anderson, Sergeant Donald Anderson, teaches physical control. I want to bring somebody else as a refresher class, how to disarm, but that's a whole different topic. But as of right now, yeah, we do have a mat session for physical control.

INV. STONECIPHER: Now, do you teach officers how to give, how to use verbal de-escalation techniques, along with, like giving commands to someone? Are they taught like how to mesh those together?

LT. MOLINA: So, what you'd see across the nation, "Drop

the knife. Drop the knife. Drop the knife. Drop the knife." It's not working, buddy, so let's try something different. Right? Like why do you have a knife? Are you safe? It looks like you're not safe, and whatever the situation is, use those, and then explain it to them. Okay? "Listen, I'm going to take you to a place where you're going to be able to talk to somebody," that would be PES. Right? "This is going to happen. I'm going to have you come back to me. I'm going to ask you to get down on your knees," or whatever the situation is, "I'm going to put handcuffs on you, because I have to transport you in my car. And policy says that I have to handcuff you. You're not under arrest," because we got to tell that to the person.

If you don't say something like that, as soon as you put those handcuffs, they're going to think they're going to jail. Any human being would think, you're in handcuffs, you're under arrest, and technically, you are, according to the Supreme Court. So, but we tell the officers to explain that, "I'm going to have to handcuff you and put you in the back of my police car. As soon as I get you there, those handcuffs are going to come off, and I'm going to take you to a room. Do you understand that? Are you okay with it?" And then you hear compliance, then do the process.

We'll call the next step, it's the open model. Open-ended questions, paraphrasing, empathetic response, and the next step is just going through the questions. When you're dealing with somebody in a mental health crisis, it's short for all those things I'm telling you, it's called [OPEN], and the last letter is N, so, it's the next step. You're informing the person what

the process is going to be. You gain two things by it, you will see whether the person will comply and they agree to the process. We always call is, include the person in the decision-making.

If I'm asking you to do something and somehow, you still have power to make some decisions yourself, you will do it better than after just giving you commands on how to do something. Sometimes, that's the proper response, but sometimes, especially with a person with mental health, if you include the person in the decision-making, the chances of getting compliance will be higher if you had the will to at least say something. "Well, I don't like this. Can you do this? Can you loosen that?" Whatever. Whatever it is, if I said, "Okay. We can work with it," I have better chances of you complying with me, than me just barking orders to you. So, include the person in the decision-making.

That's what we teach our officers. Let them feel like they still have power to control some of the situation. Some of it, not all of it, but some of it.

INV. STONECIPHER: Now, are officers trained on how to coordinate with each other, the time and distance techniques?

LT. MOLINA: Well, that's part of police work, you talk to each other, like coordinate. Like I said, we have a team. The team formation doesn't have to be the same team formation all the time. Usually, it's the contact officer, less-lethal, cover officer, arrest team. They can be spread out, they can be in a team, they can be behind a vehicle. As long as they're communicating with each other, then that's the role of the

supervisor. This is the new training. Right? The supervisor is, "Okay. This is the plan. This is what we're going to do. If that's this, this is what we're going to do. Johnny, if that's this, this is what you're going to do. You control traffic, you control this."

Definitely, communication is the key. We emulate that in the role playing. We listen; they use the radio. So, we want to make sure that they getting all the information that they need, and that they're getting the resources that they need.

INV. STONECIPHER: Now, sometimes at these critical incidents where a Code 33 has been established and officers respond to the scene Code 3, there are a large number of officers that are present. So, how are officers trained to manage, I guess, a large number of officers without the supervisor on-scene to take command?

LT. MOLINA: Okay. So, we address that. Right? So, it's called scene control, in our training. And basically, we ask them to contain the inner perimeter and the outer perimeter. So, what we tell is there is no supervisor present, then the senior officer. It falls back to the senior officer, or the officer with the most time. Just keep in mind, now half of the police department is under five years, I think, if not. So, you go back to that, and we ask them to at least control where the person is and start directing resources until the supervisor gets there. So, we ask the senior officer to step in.

INV. STONECIPHER: And now, are officers taught different techniques depending on where the incident is taking place, such as like a residence, a street, a sidewalk, a

business?

LT. MOLINA: Yes, yeah. You're going to treat it different, if you're at 16th and Mission at three o'clock in the afternoon than you're at 35th and Noriega at three in the afternoon. Pedestrian traffic is different, traffic is different. Obviously, you're going to take that into account, public safety, all right, and what needs to be done. You can give the person at 35th and Noriega more time to de-escalate, if he or she is holding a weapon than you will do at 16th and Mission, when he's holding a bat or a knife, and you have all of these people coming out of the BART Station. You cannot risk him or her assaulting somebody, so you're going to act differently. That's time to act and protect public safety.

INV. STONECIPHER: Now, in regards to like containment strategies, are officers taught about incorporating and using time and distance within containment strategies?

LT. MOLINA: Yes. We talk about moving containment, if feasible. So, we show a video out of [unintelligible] PD, where this guy actually does that in his police car. He continues to follow the person. He backs it up when the person goes to him, so we show that to the officers. And once again, if feasible, you're not going to do that at 3rd and King after the Giants game lets out. You're going to have to restrain the person as soon as you can, so the public's safe. But we do teach containment, [redacted]

[redacted]

INV. STONECIPHER: Now, kind of going back to the

Department bulletin, Response to Mental Health Calls with Armed Suspects, the Department bulletin states, quote, "An officer may not discharge a firearm at a person who presents a danger only to him or herself, and there is no reasonable cause to believe that the person poses an imminent danger of death or serious bodily injury to the officer or another person." Now, how are the officers trained to identify the difference between someone who only poses a risk to themselves and those who pose a risk to others?

LT. MOLINA: Well, if they're in a house and they're the only ones there, that's what I was telling you. We don't going in, we don't shoot at them. Now, if they're actively moving and there's the public within proximity, or they have exhibited some type of violence or behavior, and now they're not only a person in crisis, but they also a person who have committed a crime. Right? We still going to treat them the same, we try to de-escalate, it doesn't matter. But at the time, you had to take all that into consideration. You have to see the behavior. Is he compliant? Is he responding to you?

INV. STONECIPHER: Now, having said…wouldn't anyone who had a weapon always be a risk to others, just by virtue of the fact that they are armed?

LT. MOLINA: Yeah, and that's why we create time and distance, a cover, because like I was telling you, suicide to homicide. Right? It goes from this to this. Here, I'm going to kill myself and I'm going to kill you. So, the flick of a hand can mean the difference of it.

INV. STONECIPHER: Got you. Okay. So, there's another

Department bulletin I wanted you to take a look at. This is Department 17-144, this is Procedure for Booking CONREP arrestees.

LT. MOLINA: Okay.

INV. STONECIPHER: Okay. So, again, how does this relate to crisis intervention, how it's being taught in CIT?

LT. MOLINA: Well, because, are you familiar with the CONREP thing is people that were committed to a hospital or a program in lieu of the jail and now they're being released back into our community? So, by virtue of the conviction, they're saying that at one point or another, they were mental health, they were not mentally stable. So, now, they're back getting released in our community, so the officer has to be familiarized with the procedure, and also with the fact that they're dealing with a person who has [exhibiting] and been convicted of a crime, so that's the relation to it.

INV. STONECIPHER: Now, if an officer runs a subject's name, will they be identified as CONREP? Will it show up? Will that show up at all?

LT. MOLINA: I'm not 100 percent sure.

INV. STONECIPHER: Okay.

LT. MOLINA: But usually, they go to a halfway house usually, that's what the process is.

INV. STONECIPHER: Okay. If they show like a 10-35 status, would it be in CONREP?

LT. MOLINA: I have to read [unintelligible].

INV. STONECIPHER: Yeah, by all means, please. Take a look.

LT. MOLINA: Yeah. I remember things, but I'm not that good. So, this person, CONREP is another name for parole, but it's for a person that is, you know, [committed] a crime. So, this is specific locations where these people are taken. So, just for the fact that you're responding to those locations, and you're being contacted by the person, who expresses the fact that this person is a CONREP, "You should take [unintelligible] as a precaution as dealing with somebody on parole." I don't know, it doesn't specifically, talks about what's responsible to be in the [CAP] system and what Dispatch has information on.

INV. STONECIPHER: Okay. So, another Department bulletin is Department Bulletin 15-106, this is Avoiding Lawful but Awful Use of Force. So, how does this relate to crisis intervention, how it's taught at CIT?

LT. MOLINA: Basically, this is telling you that it doesn't matter how gentle or how forceful you are, just looking at another human being, being restrained by another human being is an awful thing. It might be awful to look at. It might be awful to other people's eyes, but it's a lawful thing to do when as a police officer, you're required to enforce the law and create and overcome any resistance that is impeding you doing your job. So, it talks about the community. How the community sees the use of force, how it impacts the community. How the actions of an officer can change a family, it can change the community, it can change the neighborhood, it can change the city. So, just be aware of that. I know there was a lot of talk when this came out, because lawful but awful.

INV. STONECIPHER: Uh-huh.

LT. MOLINA: What is that? But in fact, I think this came out of the Chief of Police conference and was adopted from that. It wasn't our Chief's words, it's something that he brought from the Chief of Police conference. Yeah, there was a lot of, "What is this?" But in fact, he just talks about that. He talks how the use of force affects everyone involved. And talks about assessing the situation and that what you do is lawful but it's awful to look at.

INV. STONECIPHER: And how are officers trained to comply with this Department bulletin?

LT. MOLINA: Just the same. I don't think it's a specific training, it's what the policies and procedures that have already established on the use of force.

INV. STONECIPHER: Okay. Now, we're going to take a look at Department bulletin 17-079. This is Transporting Persons Who Use Mobility Devices. This is a re-issued Department bulletin, 15-146.

LT. MOLINA: Yeah.

INV. STONECIPHER: So, again, how does this relate to the crisis interventions that officers are…

LT. MOLINA: Obviously, you're going to be dealing with somebody who has some type of disability. Once again, that person can in some type of crisis. All these bulletins relate to CIT, because somehow, they overlap on what we do, what the policy's intended to.

INV. STONECIPHER: Okay. And then, we just want to take a look at, this is DGO 5.21, the Crisis Intervention Team, CIT, Response to Person in Crisis, Call [unintelligible]. Okay. So,

the date of this DGO is December 21st of 2016. It seems to indicate that this is when there was substantive changes to the CIT program, which is around [December] 2016. Is that correct?

LT. MOLINA: Yeah, that's when the policy was adopted. It was adopted on the same day that the use of force was.

INV. STONECIPHER: Okay. Now, what was the reason for the change of this DGO?

LT. MOLINA: We didn't have any. We didn't have a policy on CIT, so the police department asked to do the training. And at the time, Office of Citizen Complaints was charged to developing the policy.

INV. STONECIPHER: Now, was this due to the Mario Woods incident that happened on December 5th, 2015?

LT. MOLINA: No. This was in the works way before Mario Woods happened.

INV. STONECIPHER: Okay. Now, did you help create DGO 5.21?

LT. MOLINA: I did. I assisted your attorney, [unintelligible] on creating some of this. There's different, like I stated before, there was different officers, civilians, activists that had an input. [Unintelligible] will bring this to our work group and share it with civilians, and [unintelligible] and it will come back, and people will have opinions about it. And I said, "No. We cannot do that. That's not humanly possible for a police officer to do that," so we change it, and recharge, and look at different tactics. We implemented the TACT concept. That's something that now POST is relying, time, atmosphere, communication, tone. So, we implemented that, we made it part of

the policy and as of right now, Peace Officers Standards and Training recognize that process or program to be the best practice on CIT, and it's written into our policy. I thought that that was awesome that we were able to comply with the State requirements and reflect that in our policy.

INV. STONECIPHER: Now, has anything changed, in regards to this and regards to training your curriculum or volunteering to do some training at all that you know of?

LT. MOLINA: In what sense?

SR. INV. VILLARREAL: It's right here.

INV. STONECIPHER: Yeah, I'm sorry. So, has anything changed on this, in regards to training or curriculum, or the [volunteerness] of the training that you know of?

LT. MOLINA: Well, we have a specific training for the policy. In spite of our ten-hour tactical training, we start our training with the policy. We have to train officers on the policy and this, [unintelligible], about the team concept, and how we're supposed to respond as a team. So, we train our officers on how to do that. So, it definitely changed our training, just [inaudible due to papers being shuffled] policy to our officers.

INV. STONECIPHER: Okay. Now, there were some terms in there that were kind of new terms in regards to your policy, so I just want to see if you can just explain them to me.

LT. MOLINA: Sure. Sure.

INV. STONECIPHER: So, tactical repositioning?

LT. MOLINA: Right. That's nothing more than change your location, it might not be a safe one. It's different if I tell

you to tactically reposition yourself. Do you have a [inaudible]? If I tell you get back, "What, to me? No, I'll never come back. [Unintelligible], I'm not a coward." Watch the message. Right? Tactical reposition. So, basically, it's just how you say it and the tactical reposition means you're not in a good situation right now. You better get behind cover, create some time and distance. That's the message.

INV. STONECIPHER: Now, you touched on earlier, it was the acronym TACT, Tone, Atmosphere, Communication, and Time. Can you just break that down?

LT. MOLINA: Yeah. So, we have a card that we pass out to the officers in the 40 hours that talks about TACT. In the front of the card, it explains what tone is, you know, the tone of voice, an array of things. Then it talks about time, it talks about atmosphere. Therapists, when they respond to a crisis, they're focused on the whole environment and what's going on. What's causing this person to go off. Right? So, the atmosphere. What is creating the environment? What is creating this person to be acting the way he or she is? Officers, we train to respond to the person's behavior. We don't pretty much look at other things unless it's biting at us or it's right in front of us, but we tend to control the person.

Therapists tend to have a broader perspective, so that's the difference between that. So, when we implement the TACT, it was something that was developed by a group of mental health people, they said these are the best tactics on how to approach a person in crisis. So, we thought that was important, even those different missions in life, right, you're a police

officer, you're a therapist, but we want to get to the same goal. So, if we can somehow incorporate both of them, and the [cops] they know how to approach somebody, I think that was the best approach. And now, POST has recognized TACT to be part of CIT training, so not only we thinking like that, but POST has a specific class on TACT, and specific videos on how to use that, on how to deal with a person in crisis.

INV. STONECIPHER: And then it mentions a lethal cover officer in there.

LT. MOLINA: Right.

INV. STONECIPHER: Should there be only one lethal cover officer?

LT. MOLINA: No, if you remember our policy on ERIW, every time an ERIW is deployed, there should be a lethal cover with that officer. So, you have to have a lethal cover with each ERIW. That's our policy.

INV. STONECIPHER: Now, if you look at section 3 on there, there's something that's mentioned that's called H/CNT. Do you see it on there?

LT. MOLINA: Section 3?

INV. STONECIPHER: Yeah. Let me see here. It should be...uh, here it is, I'm sorry. Right here. So, H/CNT.

LT. MOLINA: Hostage Crisis Negotiation Team.

INV. STONECIPHER: Okay. I just wanted to know what the definition was with that. And again, could you kind of just break down the team response concepts, what that means?

LT. MOLINA: Yeah. So, as I was telling you guys before, so we have now, this policy in place. When the call comes out as

800-CR, I think there's an explanation for the 800-CR here too. So, it should be 800-CR, 801-CR. That's something that the work group created back, I would say, 2012. If you look on the history, [Summer] will have more, but it's 2012. They came out with the two [suffix] and the classic response team. At the time, there wasn't a team per se, because the team in crisis response, or CIT, it stands for the community agencies. That's what the team response is, it's not a team of police officers. So, when you look at crisis intervention, it's not training, it's team. That means a team of community members, advocates, activists, police officers, and other agencies. That's the team. That's what crisis intervention team means.

When you're looking at responding to people in crisis, we created a crisis intervention training, which is not to be confused with crisis intervention team. So, I don't know if I'm making myself clear, but that's what it was. So, they created the CR to respond, right, so, CR means a crisis response team is needed. So, let's say you have a person standing at 24th and Mission waving a baseball bat in front of McDonald's, southeast corner. Then the call will come into Dispatch 911, "There's a person standing on the corner waving a baseball bat." Dispatch will look at it, "He's ranting and saying whatever he's saying." So, Dispatch has a criteria that they have worked with us on how they're going to look at this call. If it matches one or two of the criteria response, they're going to deem that as a crisis response team, so they're going to put it out as such, and they're going to say in the Mission for a car, A-priority, 800-CR waving a baseball bat. The CR stands for crisis response.

So, per policy, we have not trained all the Department in CIT. Where we're at right now, we're at a little bit over 40 percent in the training. So, we have trained, as of tomorrow, we will have 900 officers and [certain] personnel that are trained. So, not everyone is CIT trained. If you read this policy, it says here that in order to have a crisis response team, you have to have everybody on that team trained, but not everybody is trained. So, what we teach our officers until we get there, we would like to have the communicating officer or the contact officer to at least by the CIT officer, because he or she has received the training. And everybody else, he can direct the rest of the officers responding to fill those positions, but if not everyone is trained on CIT, so you cannot call it as CIT team, per policy, but you're still going to form the team, because this is the best practice. This is the training that we're doing until we get everybody trained.

So, you're going to be the communicator. You're going to have a person with the less-lethal, which is the ERIW. You're going to have a lethal cover. You're going to have an arrest team or detention team, and you're going to have a supervisor. So, if the person is still at the corner waving the baseball bat, is not hurting anybody, is not attacking anybody, you're going to create time and distance, you're going to block traffic. And we tell them literally, we say, "This is where you're going to respond."

Ideally, this is what we'd like officers to do if feasible, if they can, if allowed. Put cars in...close off traffic. Close off traffic in both directions. Use your cars as

a barricade, as a barrier, or use whatever you have available; trees, light poles, whatever is available. Put the cars the way that you contain the person. You can even drive on the sidewalk and contain the person [toward the tree], and then the communicator will establish rapport with the person and continue to talk.

The first sergeant at the scene controls that team. He's in charge of that team. The second supervisor responding to the scene is responsible of the outer perimeter. He or she is going to be making sure that all the resources that are available to the officers inside the perimeter and so forth. We also have instructions for lieutenants. If you're working, you responded, but your job is not to go take over the incident. Your job is to go there and make sure that your sergeants and officers have the resources that they need to contain the scene, right, as long as it takes.

So, that's what the training is. That's how our officers are being taught to do that. That's the ideal world. Right? Sometimes we're not going to have five officers to respond. Sometimes you're not going to have everybody CIT trained. So, we tell them, "If you don't have that ideally, at least you're going to have one CIT officer trained, working that shift." When we do deployment, that's our goal, to have at least one. If not, one isn't available, then the neighboring district will have to come in. Dispatch will say, "Okay. I don't have any CIT officers working in the Mission right now. Can I have an Ingleside unit that is CIT trained come?" And you have that, but that doesn't mean we're not going to respond, waiting for a CIT. That means

we're still responding but, "Uh, can I have a Bayview officer?"

So, Dispatch has the CAD system. They're able to look at who's working in the Mission; I said the Mission for example. They look at the officers that are working and they can get into the skillset for that line-up, and they can look at it and say, "Uh, 3 David 14 David is CIT trained." So, they can look at it, "Uh, 15 David is not. Okay. How about Ingleside?" So, they can look at it. They can actually call that unit and go forth. So, this is a process that we worked out with DEM, but it's as good as the person operating it. So, ideally, that's how it's supposed to respond. That's how we're supposed to do it, but sometimes, you know, life is life and things change dramatically.

So, ideally, that's the response, but we tell the officers, "Hey, that's the perfect world." We don't operate in the perfect world, so you do what you can with what you have. If you cannot have five on the team, you have three, well, go with three. And obviously, if ERIW is deployed, you've got to have lethal cover.

INV. STONECIPHER: Now, based off what we just talked about those terms I was asking you to clarify on, were those terms used at all in the old CIT training, that you know of? So, did you discuss at all, did you use things like, was this concept of team response concepts, TACT, you know, tactical repositioning, was that in the old CIT program at all?

LT. MOLINA: No. TACT was talked about, but it's not the way it is now.

INV. STONECIPHER: And you were talking about it earlier, but could you just tell me a little bit more about the

CIT database? And do officers have, can they get that through CLETS? Like just kind of clarify what that is?

LT. MOLINA: All right. So, the policy calls for a database.

INV. STONECIPHER: Yeah.

LT. MOLINA: So, the date is past, I think it was a Wednesday night; the Mission meets on Wednesdays, [unintelligible]. But on Thursday that week, I prepare a memorandum to our technology department and just say…we're required to do this, so it went into that process. Now we have what is called a CIT dashboard, which [Summer] is very much involved with. Your Department is very much involved on our compliance policy. So, it's not quite there yet. We have officers collecting information, and ideally, what we want to do is have it up and running soon, where I'd be able to look…let's say that Johnny Smith. Johnny Smith is a person that gets their 5150 all the time. I can go on my CIT dashboard, which is a work in progress, but we're almost there. I put Johnny Smith. Automatically, it will pop up how many times Johnny Smith has been 5150'ed. It will map it out for me in the city, where Johnny Smith has been detained at. How many police reports that Johnny Smith has, and so forth.

So, that's what we're hoping for. There is a little thing called HIPAA that restrains a lot of the information that DPH provides. I cannot just go and put information about Johnny. Like Johnny attends the clinic at 8th and Mission, because that will tend to identify Johnny, according to a City Attorney, that he's receiving mental health treatment. And according to the

City Attorney, we cannot do that, so it's a lot of work to be done on compliance with other laws for the data collection, but we're almost there.

What I do get though, and which I can speak of, is like every quarter, I get the amount of calls that we go to, like 800s, 801s, 910s, 5150s, 806s. So, I get that in bulk of how many times we responded, I get the locations [intelligible]. What I do is I got that information. We have NAMI, National Alliance of Mental Illness, who has a Ph.D. now, at the time he was a candidate, now he's a doctor. So, the colleges that look at this data, they worked out a deal with the City Attorney and the PD. He looks at the data from the police department, and he's able to put information out on how the officers are doing and responding to mental health crisis, just based on the specific information that I give him. So, that's the subjective data, that's something that he looks at for on the police reports.

My goal and the Department's goal is to go automated, so we don't have to go look at 900 police reports, but we can, [unintelligible], okay. how many people got diverted? How many people went to PES? How many people went to St. Francis? And I'll be able to do that by sending commands to the dashboard and hopefully, that will give me more specific data of what we're looking for. So, the data has two purposes. One is to report to the Commission, and to the City, and to the Police Department on how we're doing on responding to mental health calls. But also, it helps me to write grants to show that we do have a need for programs, that we need money for this.

So, it's dual purposes that we need it. So, we're working on it. It's a work in-progress. Summer knows very much about it, because she's part of the data committee.

INV. STONECIPHER: So, it's still kind of early, but what is the criteria for someone to be included in the CIT database? Like so, right out of the gate, to be put in there?

LT. MOLINA: Criteria in the database is just mental health detentions. And the reason we're doing that is not to identify the person as a mental health, but to provide services. My goal is to connect the person to the level of treatment that they need. A good example of that, and I can talk about him, because he signed a waiver that allows me to talk about his case. Law enforcement is not restricted by HIPAA, only people that provide services, so I'm not restricted by HIPAA.

So, I'm just going to call him, Mike. That's not his real name, but Mike got 5150 48 times in 2015. There's only 52 weeks in a year. This person got 5150 48 times, and he was my top [getter]. I look at who's getting 5150'ed, and there's about 20-something individuals that are getting 5150 all the time. So, I said, "Why is he getting 5150 so many times?" So, I contacted DPH. Obviously, they cannot talk to me, because Mike hasn't signed a waiver. They said, "Okay. Give us the information that you have, we'll get back to you." I said, "Okay, whatever."

So, I get an email from a therapist that says, "Hey, I'm working with Mike. He signed a waiver, I can talk to you." And then she explained what Mike is doing, and I find out that Mike is using substances and he's using other stuff, and he also has some organic issues. So, he's homeless, and he doesn't take his

medication as much as he needs, so I call out for an all hands-on deck meeting. We get together, we discuss the therapist didn't know that Mike is getting 5150 once a week. Honestly. Honest to God, this is, PES is here, 24th and Potrero. His therapist is at 22nd and Potrero; no connection. So, we're like, "Hey. Really? 48 times?"

But anyways, so we get together, come out with a program for him. So, 2016, 48 times. 2017, 15 times. We got him housing. Instead of taking pills, now Mike takes a shot that only requires him to go see his therapist once a month, instead of every day, every morning. He's got a place to live. Even though he's still with suicide or [violation], but he went from 48 to 15 times, and that's our goal. That's the goal of the data, to help the people who need it the most.

So, what we do is we pick the top frequent users of health services and said, "Okay. What's going on with this person?" We try to connect with that person and try to connect to the level of treatment that they need, and save the citizens money, I guess. But most of it helps the person.

SR. INV. VILLARREAL: Can we do a time check? I don't know how much time you have?

LT. MOLINA: I'm good. Yeah, whatever time [you need].

INV. STONECIPHER: We are almost done here.

LT. MOLINA: Okay.

SR. INV. VILLARREAL: I just wanted to make sure you...

INV. STONECIPHER: Yeah, yeah, appreciate it. So, again, what's the difference between introductory, advanced, and in-service CIT training?

LT. MOLINA: So, the introduction used to be…there was, before I got there, because I can only speak for when I joined the program, and was not a part of 2014, 2015, early part of 2015. It used to be the 40 hours. Some people say the basics, some people say certified, and I say, "What is it that we have?" And that was the biggest, from the summer, from when we started writing this policy. What are we calling the 40 hours? Is that Introduction to CIT? Is it a certification CIT? Who's going to get the pin, who's not going to get the pin, all these questions came out. We decided to go with the certification as the 40 hours. So, if you attended 40 hours, you are a certified crisis intervention trained officer, so you get the pin. You put it on top of your nametag, and you're supposed to, you shall wear it on the outermost part of the clothes. Right?

And so, and now, the policy requires to have a refresher class after two years. So, we limit to the 20 hours, the 10-hour CIT class; that's the tactical, So, we're giving officers their refresher class, and on that, we have trained 1500 right now. We did all patrol. We still have some people that were out on vacation, disability, but we pretty much, about 95 percent Metro, and about 87 percent Golden Gate. We continue to have that training weekly. So, we're over 1500, that's the refresher class. That's the tactical approach, the team deployment, that I've been talking to you guys about.

That is supposed to be like, not advanced, but the second level of CIT with the use of force. At the same time, it serves two purposes. It serves as a policy training and as a [CIRT], like we're advanced CIT trained. I want to continue the program.

Every two years, everyone should receive another ten hours of training, and the advanced training that we have is basically [HNT] training, but that's a whole different program for us, but that's as far as my understanding is on why we have this. A little convoluted, basic ten hours, so basic, certified, ten hours.

INV. STONECIPHER: Got you. Okay. So, I want to take a look at DGO 6.14, this is Psychological Evaluations of Adults.

LT. MOLINA: Yeah.

INV. STONECIPHER: So, again. How does this relate to CIT and is part of the CIT training?

LT. MOLINA: This is the meat and potatoes of the 5150 detention. I think this is our next project on updating this policy—1994. So, next project is to do that. These are the guidelines for 5150 detentions, where the officers need to know how to do it.

INV. STONECIPHER: Yeah. Now, are there any other databases other than CONREP and the MHFPS that law enforcement has access to, to identify subjects with mental health issues?

LT. MOLINA: I don't have…what, CONREP? That's part of the [OREC] program, right, the Criminal Justice System. So, that, everybody has access to in California. I don't have access to DPH database. Obviously, there's HIPAA restrictions on that. I only have access to what we generate in the police department. Police reports, pictures, contact information, their [file cards], if there were any, but that's it. I don't think there's any other database that has to do with mental health.

INV. STONECIPHER: All right. And then, can you just

talk about the ongoing relationship, if any, between the CIT program and the psychiatric liaison?

LT. MOLINA: The psychiatric liaison is Sergeant Kelly Kruger; she's been doing this forever. So, when I took over the program, I was overseeing behavioral science and dealing with Kelly on the side, because she was in charge of the psychiatric liaison unit, a one-person unit. So, I talked to Kelly a lot, and it made sense to me and my bosses that Kelly should be under me. I mean, we're doing the same work. At the time, I was focused more on training than anything else, but bringing Kelly under me, opened up a different door, as far as dealing with the actual people in crisis. Since we're teaching officers how to respond to people in crisis, then what do we do with them. Right?

So, the logical connection is to get involved with Kelly, because she has the connections for treatment, because she dealt very actively with the Department of Public Health in [mobile] crisis. So, by bringing Kelly under me, as part of the CIT unit, I bridged that gap, where not only CIT is involved in training, but also doing follow-ups with [mobile] crisis, and public safety risks, behaviors being displayed in the street. So, it's one in itself, they go together, so CIT.

INV. STONECIPHER: Sure. And then we've got, this is DGO 7.02, Psychological Evaluations of Juveniles.

LT. MOLINA: Right.

INV. STONECIPHER: And again, same thing. How does this relate to CIT in determining…

LT. MOLINA: The guidelines on mental health detentions

for juveniles, what to do, how to proceed, and how to contact.

INV. STONECIPHER: Sure. And then, this is DGO 8.01, Critical Incident Evaluation Notification. Again, same thing, how does that relate to CIT and part of the CIT training?

LT. MOLINA: Once again, the guidelines on how to respond to a person who might be barricaded as part of a critical incident, this is how to respond tactically, and it's definitely associated with what we're talking about, crisis response for that policy.

INV. STONECIPHER: Now, I kind of got ahead, but again, this is DGO 8.02. This is the hostage and barricaded suspect.

LT. MOLINA: Yeah.

INV. STONECIPHER: Still the same thing?

LT. MOLINA: Still the same thing.

INV. STONECIPHER: Yeah, okay. All right. Then we've got Senate Bill Number 11, which is the Peace Officer Training on Mental Health. So, do you want to take a look at that? What's your thought?

LT. MOLINA: Yeah. This is the training requirements for supervisors and field training officers. As of last year, it passed. I think it's 2015, but you had a deadline of 2016, June 17, where officers have to receive an amount of training, especially field training officers and supervisors.

INV. STONECIPHER: Good. So, is this Bill, the reason there's substantive changes to SFPD's Basic Course training or updates to SFPD policy?

LT. MOLINA: No. We've been doing that way before that. It'd be nice to get money from this, because if you're mandated

to do training, you have to provide the tools. Right?

INV. STONECIPHER: Right. So, what is the difference or overlap of CIT certification, the training received pursuant to this Bill?

LT. MOLINA: Well, it required field training officers to have the training, otherwise, they can't be certified as a field training officer. So, it's a mandate, you've got to receive that. So, when this passed, the FTO officers, we try to train as many FTOs as possible, but they also created their own program. POST sent it out, because POST is requiring agencies to do this, so they created their own program on CIT for the agencies to implement.

INV. STONECIPHER: Okay. Now, on the concept of like language or language-related issues, how are the principles of the CIT program and training applied to persons with limited English proficiency?

LT. MOLINA: You know, that's what we talk about. I know we talk about autism, but we don't have a specific CIT talk about language barriers. Sergeant Kelly Kruger does policies updates, and we talk about how to address people, non-English speaking, or people with disabilities that might not be able to communicate with you. And then, like you're trying to stop them or do whatever, obviously, they cannot hear. They might see the lights but they cannot hear you, and we talked to officers about how to use their cellphones to call translators, or call language officers, if there is anyone available, or have them use the phone and communicate, or give them a piece of paper, and writing it, and communicate with them.

INV. STONECIPHER: Did you have anything, Carlos?

SR. INV. VILLARREAL: Well, and has that changed recently, in terms of the training? Did POST, prior to 2016, was there any discussion about a language [barrier]?

LT. MOLINA: What training?

SR. INV. VILLARREAL: CIT training. Like was there any discussion at all in the training about, you know, even if it's just, "You also need to remember people might not understand what you're saying for various reasons"?

LT. MOLINA: Right. So, CIT, prior to the Bill, wasn't POST mandated, it's something that departments implemented. [Unintelligible] crisis, I think that will change soon, because a lot of bills are being generated across the nation, how do we deal with people in crisis? As far as I know, our program was created, was submitted to POST for certification. Which, that means is that POST approves it, that they're in compliance with what the standards of trainings are, and they certify us, and then we're able to certify our officers through that process. They've given their blessing with [unintelligible].

POST gives certification, then we implement the training. For the tactical training, we went through the same process. We have to go through the POST-approval, so we can certify our officers in tactical field de-escalation techniques, and we're the only agency to have it in California. No one else has this, no one else has the tactical response. So, when we talked to POST, they said you guys are the only ones. LAPD has directives that they have in writing, telling the officers, "This is what you should do when you approach a person in crisis," but they

don't provide the training for it, I mean, as far as the way that we do it. So, we're the only agency that POST has certified to have that training, tactical.

SR. INV. VILLARREAL: But just on the language issue, is there overlap in the training or instruction anywhere, in terms of approaching people who might be in crisis, but who also have language barriers, I guess?

LT. MOLINA: I don't know.

SR. INV. VILLARREAL: You don't know?

LT. MOLINA: No.

SR. INV. VILLARREAL: Okay. And then, you mentioned, you briefly mentioned something about disarming, and you wished there was more training, or you wanted to kind of implement some additional training [inaudible]?

LT. MOLINA: Well, there's different trainings. Right? So, we have people that are doing training on de-escalation. There's [unintelligible] in Washington State that does close-quarters tactics. That's something that I don't know if we're ever going to be able to do, because I don't think I should be approaching a person with a knife unless there's other stuff. But there is training up there. So, I'm looking at different things, like what they will bring next to the Department. I want to continue doing this. I think it's working for us.

I think these guidelines, because that's what I call them, this is a guideline for our officers in policies and procedures to approach a person in crisis. We can only get better. I think that we are [showing] that the police department has improved, has changed the culture on how we respond to people in crisis,

and I want to continue giving the officers training.

SR. INV. VILLARREAL: Okay. Because disarming would be…so, if someone's in crisis, you want to make sure…

LT. MOLINA: Close quarters. Like close quarters, right? Because sometimes you don't choose how things are going to go down. Right?

SR. INV. VILLARREAL: Right.

LT. MOLINA: You get put in situations that just happen. So, I want to be able to give officers the opportunity to learn tactics, disarming tactics, if they're in a hand-to-hand combat with somebody who's in a crisis. Let's say that you don't know what's behind that door. You walk into this room, and as soon as I open the door, I get attacked. I want to be able…I know there's people [unintelligible] in the Academy, they teach officers, but I want to be able to do that. I want to be able to return my firearm, and continue and say, "Hey, you know what? I came to help you, man." I want some of that training. We do it in de-escalation for the distance, but it's hard to talk to somebody, to say, "I'm here to help you. I'm really here to help you," and I'm pointing my gun at you. Right?

But how do I do that? How do I get this person to believe that I'm there to help them when I'm pointing my gun at them? So, what we do is, we tell our officers, "You can talk to the person. Put your gun on low-ready." We call it low-ready position. You can still talk to them, "Hey, I'm here to help you, man." And you can start creating time and distance, through tactical reposition, and you can still do that training. But there is necessary training also, when there is no way for me to

do that, then I have to engage you. I want to give the officers that type of training. The Academy might have something like that, but that's just my two cents on how I want to improve that.

INV. STONECIPHER: Right. Okay.

LT. MOLINA: You know?

INV. STONECIPHER: Okay. I don't have anything else. Oka. So, this interview is concluded. The official time is 12:31 p.m.

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